It's still dark when Chris Cooper, 52, steps out of her house in west Louisville. It's a Saturday morning in September, and she is that section of Market Street's only pedestrian, striding past the lime-green Get It candy store, which displays a handmade sign announcing: "Now Accepting Credit + Debit."

A block behind her house, a man carries a scarred baseball bat to walk his dog in the moonless pre-dawn. Cooper does not bother with a weapon. She will walk where she wants to walk, when she wants to walk, and will fear no evil. She is out there every morning on the weekends, and every evening during the week, walking.

Cooper, swaddled in layers against the morning chill, is six feet tall and given to gospel-sermon soliloquies in which her natural contralto soars to a helium-ringed soprano. Her voice dances through the lower end of her register as she explains her motivation to become a dedicated walker. "The obesity rate is ridiculous. Then I went to the doctor; he had the nerve to tell me I was obese. 'Chris, as bad as that sounds, you would be considered obese.'

"Well, I got an attitude," she growls, "a real bad attitude. 'Cause I'm thinking I'm cute!" she says, sliding to the top of the scale at the word "cute."

"And I'm overweight!" She's breaking glass.

She's certainly not alone.

As necessary physical activity diminishes and fast food proliferates, Louisville finds itself weighed down by a growing obesity problem.
Louisville is fat. Kentucky is fat. America is fat. Sixty-seven percent of Louisvillians are overweight, including 31.5 percent who are obese. Louisville came in No. 49 of 50, ahead of only Oklahoma City, in this year's American Fitness Index, prepared by the American College of Sports Medicine. Jefferson County is the fifth-fattest county in Kentucky, and Kentucky is the sixth-fattest state in the country, with a 90 percent increase in obesity in the last 15 years, says the Robert Wood Johnson Foundation.

Our ranking for childhood obesity is even more depressing. Among kids ages 10 to 17, more than a fifth — 21 percent — were obese, making Kentucky No. 3 for obesity in that age group. A U.S. Centers for Disease Control and Prevention report says only Mississippi and Tennessee have more obesity among low-income kids ages two to four.

We're showing the impact of all this weight. Kentucky ranks sixth for type 2 diabetes. We are seventh for high blood pressure. We are No. 6 for inactivity, and a third of us didn't get off the couch in the last 30 days. These statistics come from the 2011 F as in Fat report, a project of the Robert Wood Johnson Foundation and the Trust for American Health, using data from the annual CDC Behavioral Risk Factor Surveillance System survey.

The only consolation to all this weight in Jefferson County, if you're inclined to a competitive spirit and regional spirit — and you cherry-pick your sources — was a Men's Health Top 10 list this year that named Lexington the laziest city in the nation.

But why Louisville? Why are we chubbier than San Francisco and Burlington, Vt., are the two leastest cities in the nation? Why is Louisville No. 49 on the American Fitness Index and Minneapolis, Washington, D.C., and Boston numbers 1, 2 and 3?

"I don't know," says Dr. LaQuanda Nesbitt, director of the Louisville Metro Department of Public Health and Welfare. "Most likely it's a confluence of factors." She points to high rates of sedentary work, higher crime rates, and limited public transportation as possible causes. "If you take the bus, you have to walk," Nesbitt says.

A U.S. News & World Report list of cities with the best public transportation systems gives weight to her contention. Of the cities rated highest for public transportation, six were in the Top 10 on the American Fitness Index and seven were listed among the 10 leanest cities in a Men's Health survey.

In 1960, fat people were relatively rare; 13 percent of American adults were obese. Thirty-two percent are thin today. 25 percent will be thin in 2020, and, in 2030, if the trend continues, we will flip the 1960 statistic; only 14 percent will be thin that year, say figures from the Organization of Economic Cooperation and Development.

Cooper has a theory about all this weight, which she expounds as she heads toward Southern Parkway. It's an explanation as surprising as it is insightful. We would all still be healthy, she says, if Big Mama were still around. When Big Mama left the scene, everything started to fall apart.

We will get back to that. Suffice it to say, Big Mama has left the building.

Obesity is an epidemic. Last year, some called it the nation's biggest health problem, with consequences both deep and wide. Because we are fat, it costs more to fly us, drive us and employ us. Obesity even adds to greenhouse gases.

But the big Kahuna in all this accounting is the $1.47 billion impact of obesity on healthcare costs. Gains reaped by reduced smoking rates are now erased by the healthcare heartbreak of our weight gain. Fat plays a role in heart disease, type 2 diabetes, high blood pressure, joint deterioration and pain, life-threatening liver disease, some cancers, gall bladder disease and stroke — to name just the big problems.

And the impacts keep coming: Cities are retrofitting ambulances for wider people. New buses are wider, with bigger seats. Crash-test dummies were supersized to account for our new dimensions. In 2006, reported the Journal of Pediatrics, a quarter-million toddlers were too fat for car seats. Sales of seatbelt extenders for airlines are soaring. Revolving doors are wider to accommodate our girth. It's now possible to buy mass-produced longer hip-hugging needles, bigger caskets and hefty-size office furniture, all created for our new, bigger selves.

In 2006, the Journal of Pediatrics reported that a quarter-million toddlers were too fat for car seats.

200 children in west Louisville and east downtown kept food diaries for three days. 60% had fast food at least once a day.

40% of obese children have non-alcoholic fatty liver disease.
Men’s Health magazine named Lexington the laziest city in the nation.

A 2.8-mile stretch of Broadway from east downtown to west Louisville includes 24 fast-food restaurants.

West Louisville has half the supermarkets of the rest of the city, yet its residents are far less likely to have access to an automobile.

Our increasing bulk requires one billion gallons more gasoline to haul us in our cars. Every time the average American gains a pound, gasoline use increases by 39 million gallons.

The obese patient is four times more likely to die than a healthy-weight patient during trauma treatment, Franklin says. The mortality risk begins at the lowest end of the obesity range, a body mass index of 30 or above (about 198 pounds for someone 5’8”). The heavier the patient, the higher the mortality.

The obese patient is probably malnourished, Franklin says, and won’t have adequate protein stores for wound healing without supplemental nutrition. He may be too heavy for the motors beneath the gliding beds of the MRI or CT scanner to move him. If he is short and fat, he may be too stout to fit into an MRI or a CT scan tube for proper diagnosis. The latest in diagnostic tools are thereby denied him, and doctors must rely on lab work and a physical exam, a harder task because his large body may mean injuries are too deep to be tender to touch; swollen organs cannot be felt through the skin.

If surgery is required, the obese patient is three times more likely to develop a sometimes life-threatening infection. When his hospital care is done, he is twice as likely to be sent, not home, but to a skilled-nursing facility. In fact, although patients of healthy weight are sent home 67 percent of the time, obese patients go home 32 percent of the time, Franklin says. The rest go into nursing care or die.

Even a relatively minor injury can turn catastrophic. “You have people dying in the obese crowd in the ‘not hurt’ category, which is almost unheard of in the non-obese patient,” Franklin says. “People generally don’t die from a broken leg. . . . When you add obesity into the equation, they’ll come in and get a blood clot and die.”

For a 2007 publication, Franklin tracked patient admissions from 1993 to 2003. The number of obese patients had increased fourfold. Eight years later, there are even more.

Dr. Craig McClain, a clinician researcher at the University of Louisville, tells a chilling story. McClain is tall, with a runner’s build, a tidy mustache, and a voice that slips into the drone of a lecturer. He dresses like a banker, with a jacket, tie and tasseled two-tone loafers. He also wears a bright yellow band around his wrist, like the “Live Strong” bands once so popular. His band says, “Love Your Liver.”

McClain’s story is about a man who did not love his liver.

“Jack” was 43 when he went into the hospital to have his gall bladder removed. While the surgeon was looking around, he saw the liver looked bad and biopsied it. Turns out, Jack had cirrhosis — a disease that once meant alcoholism. But he wasn’t an alcoholic. He was obese.

That brought him to McClain, an expert in the abnormal storage of fat in the liver, an illness once known only in alcoholics or folks with hepatitis. Today, as many as a third of Americans have non-alcoholic fatty liver disease to some degree, and by 2030 half of us may. Nearly 40 percent of obese children have it, researchers estimate, as do 5 percent of normal and overweight children.

Weight loss and exercise are the best treatment for non-alcoholic fatty liver disease, McClain says, but Jack didn’t lose weight. His liver got worse. He developed liver cancer.

“He didn’t do anything I told him to,” McClain says. So Jack, a well-to-do man with a successful career, a wife and children, died. His scarred liver forced blood back into veins in the esophagus. Those veins engorged under the strain. Such distended veins are fragile, prone to rupture. His ruptured. He bled to death.

Losing even a modest amount of weight, as little as 15 pounds for a 220-pound man, can make a dramatic health difference, McClain says. But losing weight — “Nobody wants to do that,” he says. Weight loss, however, is more than a matter of willpower. Something else is going on, something the advice “eat less and exercise more” just doesn’t cover. “That doesn’t really look at the whole picture,” says Nancy Kuppersmith, a dietitian with U of L Family Medicine.

She and Demetra Antimisaris, a pharmacist, help teach primary-care physicians-in-training at U of L about obesity treatment. Their theme: There are no quick fixes. There is no drug. There is no fail-safe weight-loss plan. There is nothing simple in the medical arsenal to deal with what is fast becoming a leading cause of death.

Start with this: Food is a turn-on. To the brain, chocolate cake looks a lot like cocaine. Both trigger a blast from the neurochemical dopamine, which travels the same neural pathways whether the trigger was cake or coke. This is not a big surprise when you think about it. Drugs and alcohol are just hijacking systems we evolved to keep ourselves fueled. What is surprising is the growing evidence that, for some, the response to food looks a lot like addiction. For instance, studies show that in the obese, the brain’s response to favorite foods blunts over time. Just as a drug user...
requires more coke to get the same kick with repeated usage, for the addicted eater it takes more cake to feel pleasure.

Further, when we lose weight, the body fights back. A study in the October issue of the New England Journal of Medicine brought the sobering news that your body is still working to reverse any weight loss a year after a successful diet. In the research, 50 dieters lost an average of 30 pounds in a 10-week period. A year later, researchers found, the dieters’ hormones were still signaling hunger. Substances such as ghrelin, a known hunger cue, rose during weight loss and never returned to normal, ever frantically signaling: Eat! Eat! Eat!

The weight loss also triggered a decrease in the hormone leptin, which failed to rise to normal a year after the diet ended. When leptin drops, the body reacts as if it is starving, and hangs on to as much weight as it can. “If you don’t eat much, it’s like your body turns down the thermostat so you don’t burn as much,” Kuppersmith says.

Given the impact of obesity on health, and the complexity of the disease, one would hope that your doctor might be ready with help. But the reality is otherwise. In 2006 Kuppersmith published the results of a study in two urban Louisville clinics, where 40 percent of the patients were obese. “Despite this higher percentage of obesity,” she wrote, these patients received less advice about weight loss than the national average.

“I dare say there is a certain amount of fatalism about whether counseling for obesity actually works,” says Dr. Charles Kodner, director of curriculum for first- and second-year medical students at the University of Louisville. He says students receive about 30 hours of nutrition education in the first two years of medical school. But the focus is not so much about preventing obesity as it is managing its consequences.

“In a doctor’s office setting, there just isn’t the time or resources to do more extended counseling,” Kodner says, adding that “all meaningful weight-loss is at the community level — community activities or support or group projects — not what their doctor tells them to do.”

Chris Cooper marches along Southwestern Parkway, ignoring the black-and-white cat trailing her, and shouts greetings to a bus driver parked ahead as the sky turns from black to deep blue. Cooper talks to everyone she sees.

She started the Shawnee Walking Club last summer. When she went to work for a lawyer downtown, she had to move her weekday walking to evenings. So now the members walk without her on weekday mornings.

Jane McDaniel is a weekday walker. She describes herself as “a little short fat lady” who didn’t need a doctor to tell her she was overweight. “I told myself: My scale told me.”

Only a few of the walkers knew each other before they joined the club. Now, they’re a force. “We’re all in each other’s corners,” McDaniel says. They also weigh in together every month at McDaniel’s house. All have lost weight and inches. Cooper, who can usually make the weigh-ins, has lost 37 pounds.

Want to see what she looked like 37 pounds ago? Wait for a TARC bus. There is Cooper’s image on the side, bigger than life, holding up a pair of tennis shoes in an ad promoting Louisville’s Healthy Hometown initiative, a program paid for with $7.9 million in federal funds.

While Cooper is involved with Healthy Hometown, the walking club was her idea. The folks at the health department didn’t even realize she and her ladies had added a weigh-in. And now Cooper is cooking up a downtown walking group. She has asked Mayor Greg Fischer if he will walk with the new group every once in a while.

Healthy Hometown includes programs to make it easier to bike and walk in urban neighborhoods. Its efforts have helped make school lunches healthier, and helped the city’s four hospitals with labor-and-delivery facilities standardize breastfeeding education. (Breastfeeding is linked to lower rates of childhood obesity.) It is helping local restaurants include nutrition information on menus, and it has launched a number of incentives to make fresh fruit and vegetables more available in neighborhoods without supermarkets.

Old Farm Boy Market straddles the California and Park Hill neighborhoods, at the corner of Oak Street and Dixie Highway. Across the street is Goody Goody Liquors. Catty-corner is a bright yellow and red Dixie Chicken, where 50 wings will set you back $19.99.

This is considered one of the city’s food deserts, neighborhoods where you have to walk a long way to find fresh fruits and vegetables. West Louisville has half the supermarkets of the rest of the city — one per 25,000 people compared with one per 12,500 for Louisville as a whole — yet its residents are far less likely to have access to an automobile, according to the Community Farm Alliance. The car-less rate ranges from 20 percent to 70 percent in the blocks around Old Farm Boy. So it is in the right place to become one of the new Healthy-in-a-Hurry Corner Stores, and it won a grant through Healthy Hometown funding to help it provide fresh fruits and vegetables.

The Old Farm Boy Market is clean and well-lit on a Thursday afternoon in October, with a faint aroma of disinfecting soap. The produce chiller is in the back corner. It is more than half empty. Amid cheerful hand-lettered signs for blueberries and strawberries is a faded collection of nature’s bounty: a few onions, three bunches of fresh greens and a half-dozen wan oranges, deflated like flat tires. At the register, two middle-school kids buy chocolate.

The health department’s Nesbitt says the store is still learning to market produce to its customers, but for the customers, it’s hard to break the habits of a lifetime, especially when you’re surrounded by aggressively marketed high-fat, high-salt, high-sugar foods. You’re never far from a bag of chips in California or Smokeytown or Shawnee. The neighborhoods are rich in convenience stores. A 2.8-mile stretch of Broadway from east downtown to west Louisville is home to 24 fast-food outlets — one every 200 yards for three miles.

This convenience has consequences. A 2006 study in the American Journal of Preventive Medicine showed that the mere presence of a supermarket in a community was associated with lower obesity rates. The same study showed that convenience store numbers correlated with greater obesity. Another study, this one in the American Journal of Public Health, found that fruit and vegetable intake by African-Americans increased 32 percent for each additional supermarket in a census tract.

The culture is programmed for obesity.

“It isn’t just about individual choice,” says Richard W. Wilson, chair of the Health Promotion and Behavioral Sciences department at U of L. “Somewhere around 1980, Americans didn’t all of the sudden decide to become glutons. They didn’t all decide to become couch potatoes. They didn’t say, ‘I don’t want to exercise anymore, and I want to eat more fat and calories.’”

The glut of our glutton, says Wilson, “has more to do with the circumstances that have been created, that are superseding conscious individual choices people make about exercise and diet.” Look at school lunch programs, he says. “Until very recently, choices through the USDA-sponsored school lunch program have been ter-
Heavier workers are 194% more likely to call in sick, studies show. The cost to business is estimated between $3.38 billion and $6.38 billion a year.

Increased fuel use and increased food production boost carbon dioxide emissions. If everyone lost 10 pounds, one study estimates, CO₂ levels would fall by 110 million tons.

Sales of seatbelt extenders for airlines are soaring.

Between 1990 and 2000, widespread obesity forced U.S. airlines to use 350 million gallons more fuel to keep us aloft.

terrible. We've been feeding kids tater tots and chicken nuggets. Kids didn't choose that. That's a structural thing.

Even the way our communities are built contributes to obesity, Wilson says, with sprawling residential subdivisions hemmed by high-traffic thoroughfares. "How many roads have no sidewalks and really no safe shoulder for walking? Why is that? I didn't choose that. You didn't choose that," he says.

"That's not to say people cannot learn to make better choices. But we have tended to blame individual people for being overweight. I think it's not fair. I think it's society's problem."

Chris Cooper knows whom to blame. Big Mama. Or, rather, her disappearance from our lives.

"I had a grandma, Anna Adams," Cooper says. "Honey, she cooked. We didn't know what it was to go out to eat." She slides into her preaching voice: "My grandmother made us work. We worked in the yard. We worked in the garden. We had apple trees. We had grapevines growing. My grandmother cooked breakfast for us in the morning. We had lunch on the weekends. She made homemade everything."

Compare this to the findings of a 2008 study by U of L student researcher Angelique Perez. She looked at the eating habits of middle-school children in the food desert — in this case, west Louisville and east downtown. Two hundred children kept food diaries covering three days, which included a weekend. Sixty percent had fast food at least once a day. Ninety percent had one serving or fewer of fruits and vegetables daily.

Not only was Big Mama missing; sometimes, no one was there: The survey showed that 89 percent of the kids reported eating at least one meal or snack alone. Thirty-seven percent are alone twice daily. Ten percent are alone three times daily.

"There's no more Big Mama," Cooper laments.

Is she onto something? Is there a Big Mama deficit behind our eat-in-a-rush, fast-food, soft-drink, skip-family-mealtine habits?

"I think there's some merit to that," Nesbitt says. She took the reins in the Louisville Metro Department of Health and Welfare in July, after Dr. Adewale Troutman left to take a post at the University of South Florida. Raised in Flint, Mich., with a medical degree from Wayne State University School of Medicine in Detroit and a master's in public health from Harvard, Nesbitt was a deputy director in the District of Columbia Department of Health before taking the job here.

"My parents made me go outside and play," she says. "It was unconscionable for your mother to allow you to sit in the house all day during the summer... Now we have a society where most of our children are entertained by screen time. That's their form of recreation. There's no one really watching the kid comes home and helps himself to half a pack of cookies."

"We have to get parents to understand that they are authoritative. I met a mom who had a morbidly obese two-year-old who told me the two-year-old used to fight her for her Pepsi. It was quite shocking to me that a two-year-old could control a parent."

I da Offutt, 56, is in a wheelchair. Obesity put her there.

"I could walk, but it hurts me with all the weight," she says. "I was a certified nurse's aide, and I hurt my back working. When I couldn't work anymore, I was sitting around depressed, just eating, eating, eating." When she stopped, she weighed 398 pounds.

Cooper was teaching a healthy-eating class at the Shawnee Community Center. Offutt joined. Cooper invited her to walk, proposing Offutt walk a little bit and then ride, and then walk a little bit more. "I know you want to get up out of that chair so you can start doing stuff you used to do," Offutt says Cooper told her. "She was right."

Offutt's first time out, she walked half a block. The next time, she made it almost the whole block. And that's how she does it, in short bursts of walking between longer rides. She also changed her diet. "I was a bread eater," she says. "I eat more vegetables. I eat toast. I eat meat. I eat the wheat bread, green vegetables, salads, a baked chicken."

The pounds started dropping. She's lost about 60.

"Our goal by next summer is for her to throw that wheelchair away," Cooper says.

So is Chris Cooper the Big Mama in her neighborhood? Or is Big Mama now the Shawnee Walkers, who keep tabs on one another? Their group approach to fitness is a hallmark in programs that get people to change ingrained behavior, including overeating.

"I see people in the neighborhood all the time; they say, 'Chris, I want to walk.' But they don't come," Cooper says as she heads for home. "It's a learning process. I just pray everybody realizes before it's too late, before they take insulin, before they have a heart attack — when they don't have a choice."

"I pray they realize. If you start early, you always have a choice."