
Why Smart People Still Struggle With Weight

*A free guide for anyone who has worked hard at this
and wondered why it didn't hold.*

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BREAUX MEDICAL

Precision Health. Relational Care.

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A NOTE FROM DR. BREAU

Why I Wrote This

Early in my medical training, a patient came to me asking for help with her weight. I gave her the advice I had been taught to give: eat less, move more. I added a referral to a nutritionist and moved on to my next patient.

I remember feeling insincere as I said it, because I already suspected that advice would not be enough. What I did not know was how much that answer was leaving out.

Later when I was working as a primary care doc, I learned that the American Medical Association had formally recognized obesity as a disease in 2013. Others had done so before, but what the AMA did was a huge deal. That was the year I graduated from medical school, and nobody had taught me about it. I also learned that approved medical treatments for obesity already existed, and that decades of careful science had already described the biology which I had just told that patient to overcome with more effort.

That gap between what the science knew and what patients were being told has shaped my career ever since. I went on to become board certified in obesity medicine, lifestyle medicine, and culinary medicine. It was never about collecting credentials. Each one came from running into the same limits with patients and realizing I had more to learn, which is how I expect to spend the rest of my career. I have also spent the years since having a very different conversation with patients than the one I had that day.

Here is what I have noticed since. When bodies and weight come up, the conversation stops being clinical and turns moral almost immediately. People get labeled disciplined or lazy, strong or weak. Medications get called cheating. Patients arrive in my office already carrying a verdict about themselves, usually delivered years earlier and repeated ever since.

That moral framing is not just unkind, it's inaccurate, and it costs people years of their health.

The problem was never a lack of information but a lack of complete information. We give generic health advice that fits neatly into rapid fire TV interviews and public health guidelines. What patients are rarely told is that appetite, reward, sleep, stress, muscle, insulin, and the food environment are all part of one system, and that this system actively defends stored fat. Once you understand that, the story changes. You stop asking what is wrong with you and start asking what your body is responding to.

My perspective here is not only professional. I have lived with a chronic condition myself, and I know what it feels like to be rushed, dismissed, and left without answers for years. I know the difference between being handed advice and being genuinely partnered with.

That difference is why I left traditional practice and built Breau Medical. I wanted to slow medicine down enough to look back at a person's history and lived experience, look ahead at their risks, and look within for what actually motivates them. The work is closer to coaching than counseling, because the goal is to partner with people through change rather than to advise them from a distance.

I can only see so many patients, though, and the science in this guide should not be limited to the people who happen to find me. That is why this guide is free.

My hope is that you finish it with two things. The first is relief, because most of what has made this hard for you is biology rather than character. The second is a plan, because understanding your biology is what finally lets you work with it.

If you want help building that plan, I would be glad to be in your corner.

To the joy of living proactively,

Barry Breaux, MD, MBA

Oakland, California — September 2026

Introduction

Jordan is 46 years old, runs a finance team, and has never been described as lazy by anyone.

Jordan has lost the same 25 pounds three times, first with a low-carb plan, then with a food tracking app and a spin bike, and most recently with a 5 a.m. boot camp. Each time the weight came back within a year, and a few extra pounds came with it.

At every annual physical, the labs come back with the word *normal* next to each line. Meanwhile, the A1c has crept from 5.4 to 5.9 over six years, and the waist has grown two inches even in the years when the scale barely moved. Afternoons bring a hard energy crash around three o'clock, and sleep runs about five and a half hours on weeknights.

The advice at each visit has been the same. Cut back on carbs and be consistent. Somehow nobody has ever explained why consistency works for six months and then stops working.

Jordan is not a real patient, but rather a composite of many people I've cared for, with the details changed. If any of it sounds familiar, you're in the right place.

This guide exists because the standard explanation for weight struggles is wrong, and being wrong has consequences. When we tell smart, capable people that their weight comes down to discipline, we leave them blaming themselves for the behavior of a biological system built to defend stored fat.

The science says something different, and it has for decades. Your body runs a weight control system that involves hormones, brain circuits, muscle, sleep, stress, and your food environment, and that system often defends against weight loss by raising hunger and lowering the calories you burn. None of this is an excuse, and it does not mean your choices don't matter. It means your choices work best when you understand what you're working with.

The first four chapters explain you: why fat matters more than weight, why willpower fails, which four drivers change your biology, and how change really happens. The next two chapters cover the medical tools, meaning the measurements worth tracking and the medications worth considering. The last chapter helps you build a strategy of your own. You can read it straight through in about an hour, or skip to the chapter you need most. Every chapter answers the questions patients ask me most often, corrects the myths that get in the way, and ends with a takeaway you can act on.

This guide is education rather than medical advice. Nothing here replaces a conversation with your own clinician.

I'll come back to Jordan at the end.

CHAPTER 1

The Problem Isn't Your Weight. It's What Your Fat Is Doing.

Picture two people who both weigh 190 pounds. One lifts weights three times a week, has normal blood sugar, and carries most of her extra weight on her hips and thighs. The other sits at a desk all day, carries his weight around his middle, and was just told his liver tests are "a little high." It's the same number on the scale, but a very different health status and direction.

That's the first idea I want you to take from this guide. **Your weight is a clue, not a verdict**, and what matters more is what your body fat is doing.

Why weight is a rough measure

Most doctors screen with body mass index (BMI), a number based on your height and weight. BMI is useful the way a smoke detector is useful: it tells you to look closer, but it can't tell you whether there's a fire.

BMI can't tell muscle from fat. A muscular athlete can land in the "obese" range. Meanwhile, a person with little muscle and a lot of belly fat can land in the "normal" range and still have serious risk.

BMI also works differently for different groups. For example, many people of Asian descent develop type 2 diabetes at lower weights, which is why diabetes screening may begin at a BMI of 23 rather than the 25 used for many other adults.

In 2025, a global group of experts proposed a better approach, though it is not yet universally adopted. The first step is to confirm extra body fat with more than BMI, such as a waist measurement or a body fat scan. The second step is to ask the real question, which is whether that extra fat is already harming how your body works. Their framework sorts people into two groups:

- **Preclinical obesity** means you carry extra fat, but your organs still work normally. Your risk is higher, and this is the best time to act.
- **Clinical obesity** means the extra fat has already led to organ problems or meaningful limits on daily activities, when those problems can be attributed to the excess fat. High blood sugar, joint pain, and sleep apnea are examples, though having one of them does not automatically place you in this group.

This shift matters because it moves the conversation from "What do you weigh?" to "How is your body doing?"

Three questions that matter more than weight

1. How much fat do you carry?

Body fat percentage is the share of your weight that comes from fat. There is no diagnostic standard, and cutoffs vary by age, ancestry, measurement method, and professional organization. As a rough screening convention, many clinicians treat about 25% or more for men and about 32% or more for women as a sign of excess fat. A body fat scan or a waist measurement tells you far more than the scale alone, and Chapter 5 covers how to measure.

2. Where is it stored?

Where your fat sits matters as much as how much you carry.

IN PLAIN ENGLISH: YOUR BODY IS A HOUSE

- **Fat under your skin** is the pantry. It's a fairly safe place to store extra energy, and it's the fat you can pinch.
- **Fat deep in your belly** is clutter piled around the furnace. It surrounds your organs and sends fat and inflammation straight to your liver.
- **Fat inside your organs** is boxes stacked in the hallways. When the pantry is full, fat spills into places it doesn't belong, like your liver, muscles, pancreas, and heart.

A bigger waist usually means more fat around your organs, which is why two people with the same weight can have very different risk.

3. How well is your fat working?

Fat is more than stored energy. It's also an active organ that sends hormones to your brain, liver, and muscles.

Healthy fat tissue stores energy safely, like a well-run warehouse. However, everyone has a limit to how much fat they can store safely. That limit is different for each person, and your genes help set it.

When you pass your limit, fat cells get overstuffed and inflamed, and fat starts to spill into the liver and muscles. That's one reason some people get type 2 diabetes at a "normal" weight, while others carry more weight with fewer problems.

Weight gain is often a signal

When a patient tells me they've gained weight, I treat it like a check engine light and look for what's behind it. Common causes include:

- **Insulin resistance.** Your cells stop responding well to insulin, the hormone that moves sugar out of your blood, so your body may make more insulin to keep your blood sugar controlled. That pattern often travels with greater hunger, easier energy storage, and more difficulty releasing stored fat, though it is one part of a larger system.
- **Poor sleep.** Short or broken sleep raises hunger and cravings.
- **Chronic stress.** Stress makes good choices harder and comfort food more tempting.
- **Muscle loss.** Muscle mass and strength tend to decline gradually with age, especially without resistance training. With less muscle, your body has fewer places to store and burn sugar.
- **Life stages.** Around menopause, fat tends to shift toward the belly.
- **Medications.** Some antidepressants, steroids, diabetes medicines, and seizure or mood medicines can cause weight gain. Never stop a medicine on your own, but do ask your doctor about it.
- **Your surroundings.** Long workdays, easy fast food, and little time to move add up, and Chapter 2 explains how.

The problem with blame

Most people who struggle with weight have been told, many times, to "just eat less and move more." If that advice worked on its own, you wouldn't be reading this.

Blame hurts, and it also backfires. Studies show that people who feel shamed about their weight tend to eat more, move less, and put off medical care. Shame is not a treatment.

In 2013, the American Medical Association recognized obesity as a disease. The decision reflected how complex the body's weight control system is, rather than any lack of effort. It also acknowledged that this system sometimes needs medical help.

The cost, and the good news

Extra fat, especially in the wrong places, is linked to a long list of chronic conditions. These include:

- Type 2 diabetes and high blood pressure
- Heart disease, heart failure, stroke, and an irregular heartbeat
- Fatty liver disease
- Arthritis and chronic pain
- Sleep apnea, depression, and several types of cancer

That list can feel heavy, but there is good news. You don't need to reach an "ideal" weight to get big benefits.

- **Blood sugar:** In a large study called the Diabetes Prevention Program, people who aimed to lose at least 7% of their weight and to be active at least 150 minutes a week lowered their relative risk of developing type 2 diabetes by 58% over about three years, compared with a placebo group.
- **Joints:** In a study of adults with knee osteoarthritis, each pound of weight loss was linked to about four pounds less load on the knee with every step.
- **Liver:** In one study of people with biopsy-confirmed liver inflammation, 90% of those who lost at least 10% of their weight had that inflammation resolve, although only a minority lost that much.

For many people, losing just 5% to 10% of body weight improves blood sugar, blood pressure, and liver health. Fat around the organs often decreases substantially, sometimes out of proportion to what the scale shows. Small changes, repeated, change the direction of your health.

COMMON QUESTION: "CAN I BE HEALTHY AT A HIGHER WEIGHT?"

Some people can, at least for now, and that's what preclinical obesity describes. However, long-term studies show that many people in this group develop blood sugar, blood pressure, or heart problems over the next ten years or so. If you're healthy right now, that health is worth protecting, not ignoring.

COMMON QUESTION: "IS BELLY FAT REALLY WORSE?"

Yes, fat around your organs is more closely tied to diabetes, heart disease, and fatty liver than fat on your hips and thighs.

MYTH VS. SCIENCE

Myth: You can burn belly fat with crunches.

Science: You can't choose where you lose fat, but exercise and healthy weight loss tend to shrink deep belly fat early, sometimes before the scale moves much.

TRY THIS TODAY: THE STRING TEST

Cut a piece of string as long as you are tall, and fold it in half. Wrap it around your waist, halfway between your bottom rib and the top of your hip bone, which is usually near your belly button. If the ends don't meet, your waist is more than half your height. That's a sign of extra belly fat worth raising with your doctor. The UK's national health guidelines use this same "half your height" rule.

THE TAKEAWAY

What matters most is how much fat you carry, where it sits, and how well it works. Extra weight is not a character flaw but a signal worth understanding, and even modest changes can make a real difference.

CHAPTER 2

Why Willpower Fails

Try holding your breath for as long as you can. For the first 30 seconds or so, it feels easy. After a minute, the urge to breathe becomes overwhelming, and eventually your body wins. Nobody would call that a lack of willpower.

Hunger works in a similar way. You can override it for a while, but your body has powerful systems built to make you eat, and over weeks and months, those systems tend to win.

This chapter explains how those systems work. Once you understand them, it becomes clear why smart, disciplined people still struggle with weight, and why the answer is a better strategy rather than more guilt.

Genes load the gun, environment pulls the trigger

In the early 1960s, about 13% of American adults had obesity. By 2010, that number had climbed to about 36%, and it reached 40.3% in the most recent measured national survey, covering 2021 to 2023.

Our genes did not change in 50 years, so the main cause has to be something in the world around us.

The power of this interplay shows clearly in the Pima Native Americans. When the U.S. and Mexico border split their population in the 1850s, two groups with identical genetic ancestry entered very different worlds. The Pima in Mexico kept a traditional farming lifestyle, with average weights and healthy body fat levels. Meanwhile, the Pima in the United States lost their farmland, moved onto reservations, and relied on modern food supplies. That environmental shift triggered dramatically higher rates of obesity and type 2 diabetes in the U.S. group.

Genes still matter a great deal, though. Studies of twins and adopted children suggest that genes explain 40% to 70% of the differences in body weight between people, which means they help decide who is hit hardest when the environment changes. That is a population estimate, not a personal destiny.

A food world built to be overeaten

Food today is cheaper, easier to get, and more tempting than at any other time in human history. Many packaged foods combine sugar, fat, salt, texture, and convenience in ways that make passive overeating easier.

In 2019, researchers at the National Institutes of Health tested this directly in a tightly controlled trial. Twenty adults lived in a research center for four weeks, eating mostly ultra-processed food for two weeks and mostly whole, minimally processed food for the other two. The two menus were designed to match the amounts of calories, sugar, fat, fiber, and salt offered, and people could eat as much as they wanted. On the ultra-processed diet, they ate about 500 more calories a day without trying and gained about two pounds. On the whole-food diet, they lost about two pounds. The food itself changed how much they ate.

You may have heard that the obesity epidemic came from people eating about 200 extra calories a day. That number is close, but the fuller story is more interesting. A mathematical model estimated that the average daily imbalance behind the weight gain was very small, roughly 7 calories a day.

However, holding those new, higher weights eventually required about 220 more calories a day than before. These are population estimates rather than a rule for any one person.

IN PLAIN ENGLISH: THE BATHTUB

Think of your weight as the water level in a bathtub with the faucet running and the drain open. The faucet is the calories you eat, and the drain is the calories you burn.

The key detail is that the drain's speed depends on the water level, because the higher the water, the harder it pushes out through the drain. Turn the faucet up a little and the level rises, which speeds up the drain, until the water flowing out matches the water coming in. The level then holds steady at a new, higher point.

Your body works the same way, because a bigger body burns more calories. As a rough rule, eating 10 extra calories a day eventually raises weight by about one pound, on average, with roughly half of that change arriving in the first year.

Your brain has three systems that control eating

1. The thermostat

Deep in your brain, a region called the hypothalamus works like a thermostat for body fat. In 1994, scientists discovered a hormone called leptin, which fat cells release in proportion to how much fat you carry. Leptin tells your brain how much energy you have in storage. When you lose fat, leptin drops, and your brain responds by raising your hunger and lowering the number of calories you burn.

A rare genetic condition shows how powerful this system is. Some children are born unable to make leptin. They feel intense, constant hunger and gain weight rapidly, even as toddlers. When doctors gave these children leptin, their hunger calmed down and their weight came down. Their struggle came from a missing signal, not from a lack of willpower.

This thermostat has an important flaw: it defends against weight loss more strongly than it resists weight gain. For most of human history, starvation was a far bigger threat than having too much food, so our bodies evolved to hold on to stored energy.

2. The reward system

Your brain also has a reward system that drives the feeling of wanting, and seeing, smelling, or even thinking about tempting food can switch it on. Modern, highly palatable (tasty) food and constant food ads keep this system busy all day long.

3. The brakes

The front part of your brain, called the prefrontal cortex, handles planning and self-control. This is what most people mean by willpower. It works well when you are rested and calm, but stress, poor sleep, and strong hunger all weaken it, which is why late nights and hard days so often end in the snack drawer.

IN PLAIN ENGLISH: A CAR ON A HILL

Imagine driving a car with a very sensitive gas pedal down a long hill. The thermostat is the hill, the reward system is the gas pedal, and willpower is the brakes. You can ride the brakes for a while, but brakes wear down, especially when you are tired or stressed. A better plan is to change the road, and Chapter 3 shows how.

Why your body fights back after weight loss

When you lose weight, your body treats it as a threat and responds on several fronts. One model estimated that for every 2.2 pounds (1 kilogram) lost, appetite rises by about 100 calories a day, while the calories burned drop by about 25 a day. Individual responses vary, but appetite appears to be the bigger force.

In careful lab studies, people who lost 10% of their body weight burned about 300 to 400 fewer calories a day than scientists predicted based on their new size. Several changes add up to that difference:

- **Muscles:** Muscle efficiency increased by roughly 20% during low-intensity activity, so easy movement burned fewer calories.
- **Nervous system:** It shifted into an energy-saving mode.
- **Thyroid:** Thyroid hormone is a master regulator of metabolism, because it helps set how fast nearly every cell uses energy. After weight loss, active thyroid hormone levels can fall within the normal range, which contributes to energy conservation.

When researchers gave these people small doses of leptin, many of these changes reversed, which strongly suggests the slowdown is driven by biology rather than behavior. The brain changes too. Scans taken after weight loss show more activity in areas tied to wanting food and less in areas tied to self-control, so food looks better and it becomes harder to say no.

The most famous example comes from the TV show *The Biggest Loser*. Scientists followed 14 contestants for six years after the show ended. Most had regained much of their weight, and on average their resting metabolism was still burning about 500 fewer calories a day than expected for their size. This was a very small and unusual group after extreme weight loss, so the numbers are dramatic, but the direction is familiar. It helps to picture a stretched rubber band, because the further you pull, the harder it pulls back. This is why most people who lose weight through dieting alone regain most of it within a few years.

Why counting calories feels impossible

Many weight loss plans start with counting calories, but people are not very good at it. In one well-known study, people who said they could not lose weight on a low-calorie diet were underestimating what they ate by nearly half, and overestimating their exercise by about half.

That study did not establish deliberate deception, because self-report is intrinsically difficult. Underestimating what we eat is common, and it shows up even in people trained in nutrition.

Your body keeps a memory

New research shows that your body can hold on to signs of past weight gain long after the weight is gone.

- **Fat cells:** In a 2024 study, researchers compared fat tissue from the same people before weight loss surgery and again two years later. Even with the weight gone, the fat cells still showed an "obesity pattern" of gene activity. Genes that help fat cells store and use energy normally stayed turned down, while genes linked to inflammation and scar-like tissue stayed turned up. In mice, prior obesity left lasting epigenetic changes (which alter gene expression) in fat cells, and those mice regained weight faster when a high-fat diet returned.
- **Immune cells:** A 2026 study found something similar in the immune system. Helper immune cells carried chemical marks from obesity, and the authors estimated that recovery may take

years, perhaps 5 to 10, although they did not follow the same people for that long. In a small group of 13 people, weight loss with semaglutide did not return these cells to normal during the six months studied. The study does not show that these immune changes cause regain in people.

IN PLAIN ENGLISH: THE FOLDED PAGE

Think of a piece of paper that has been folded. Even after you flatten it, the crease remains, and the paper wants to fold along that line again.

This research is still early, and it does not mean your efforts are wasted. It does mean that keeping weight off is a long-term project, and that regain reflects biology rather than personal failure.

What people who keep weight off do differently

The good news is that many people do keep weight off. The National Weight Control Registry tracks more than 10,000 people who have lost at least 30 pounds and kept it off for at least a year.

Researchers have compared these successful maintainers with people at the same current weight who never had to lose weight. The maintainers consistently stand out in four ways:

1. They get much more daily physical activity.
2. They weigh themselves and track their food regularly.
3. They eat in fairly consistent patterns rather than in cycles.
4. They watch far less television than the national average.

Most people in the registry are white women, so the findings may not apply equally to everyone. Still, the lesson is encouraging: keeping weight off is possible, but it takes a system that works with your biology rather than against it.

COMMON QUESTION: "ISN'T IT JUST CALORIES IN, CALORIES OUT?"

Yes, energy balance is real, and calories do count. The catch is that your biology controls both sides of the equation. When you eat less, your body pushes back by raising hunger and lowering the calories you burn, which is why simply trying harder so often fails.

COMMON QUESTION: "DO I HAVE A SLOW METABOLISM?"

Probably not, at least not as the cause of your weight gain. Larger bodies actually burn more calories than smaller ones. The real slowdown tends to appear after weight loss, as your body tries to defend its old weight.

COMMON QUESTION: "IF IT'S IN MY GENES, WHY TRY?"

Genes shape your risk, but they don't seal your fate. In the Diabetes Prevention Program, healthy lifestyle changes lowered diabetes risk even in people who carried high-risk genes.

MYTH VS. SCIENCE

Myth: People with obesity just lack discipline.

Science: Obesity rates nearly tripled in a few decades, and willpower did not suddenly collapse across the country. Many people with obesity are highly disciplined in their careers and family lives. The difference lies in biology and environment, not character.

TRY THIS TODAY: THE CUE COUNT

For one day, keep a simple tally of every time you see, smell, or hear about food you didn't plan to eat. Count office snacks, drive-through signs, food ads, and delivery app alerts. Most people are surprised by how many times their reward system gets triggered before dinner. Noticing these moments is the first step toward changing the road instead of riding the brakes.

THE TAKEAWAY

Your body has a thermostat, a reward system, and a set of brakes, and in today's food world, the first two usually overpower the third. After weight loss, your body pushes back with more hunger and a slower burn. Struggling with weight is not a character flaw. It is biology meeting a modern environment, and it calls for a smarter strategy, not more guilt.

CHAPTER 3

The Four Drivers of Metabolic Health

In Chapter 2, I compared eating to driving a car down a long hill with a sensitive gas pedal and brakes that wear down. Most diets ask you to ride the brakes harder, and that rarely works for long. A better plan is to change the road, so the car is easier to control in the first place.

You can't talk your thermostat out of defending your weight, and you can't "will" your reward system into ignoring a bakery. You can, however, change the signals those systems receive every day. At Breaux Medical, we organize those signals into four drivers of metabolic health, which we call the **4S Framework: Sleep, Savor, Sweat, and Serve**.

Driver	What it includes	How it helps your biology
Sleep	Enough sleep, at regular times	Restores your brakes and calms hunger hormones
Savor	Whole foods, protein, fiber, and eating with attention	Turns down the gas pedal and turns up fullness signals
Sweat	Daily movement, cardio, and strength training	Builds muscle, improves blood sugar, and helps keep weight off
Serve	Success, Engagement, Relationships, Values, and Emotional Agility	Lowers stress and keeps you steering in the right direction

Sleep: the driver that resets your brakes

Sleep is the driver people skip first when life gets busy, and it may be the one that matters most for appetite.

When you're short on sleep, your hunger hormones shift in the wrong direction. In one classic laboratory study of healthy young men, just two nights of four hours of sleep had three effects:

- Leptin, the fullness hormone, went down.
- Ghrelin, the hormone that drives hunger, went up.
- People felt hungrier, especially for sweets, salty snacks, and starchy foods.

Poor sleep also weakens your brakes. Brain scans show that after a sleepless night, the self-control areas of the brain quiet down while the reward areas react more strongly to food. When researchers combined many short-term experiments, they found that people ate about 385 more calories on days after short sleep, while burning about the same number of calories as usual.

The reverse also works, which is the hopeful part. In a 2022 study, adults with overweight who usually slept less than 6.5 hours were coached to sleep about an hour longer each night. Without being told to change their diets, they ate about 270 fewer calories a day.

Savor: food that works with your biology

Savor means choosing foods that work with your biology and taking the time to enjoy them. The NIH study in Chapter 2 showed that ultra-processed food can lead people to eat about 500 extra

calories a day without noticing. Whole foods do the opposite, because they fill you up on fewer calories.

Two nutrients deserve special attention:

- **Protein** is the most filling part of a meal, and it helps protect your muscle when you lose weight.
- **Fiber**, found in vegetables, beans, fruit, and whole grains, slows digestion and feeds the healthy bacteria in your gut.

Both protein and fiber can stimulate natural fullness hormones, including GLP-1, the same signal that many newer weight loss medicines act on. Food does not produce that signal at the strength or the duration a medication does.

How you eat matters too. Fullness signals take time to travel from your stomach to your brain, so eating quickly can carry you past the point of fullness before your brain gets the message.

IN PLAIN ENGLISH: TWO VOLUME KNOBS

Think of your meals as having two volume knobs. Ultra-processed foods turn up the reward volume, so you keep wanting more. Protein, fiber, and whole foods turn up the fullness volume, so your body can tell you when it's had enough.

Sweat: the driver that keeps weight off

Sweat covers all the ways you move, from walking and taking the stairs to cardio and strength training.

Here is something that surprises many people: exercise alone usually leads to only modest weight loss. One reason is that the body adjusts by raising hunger and by quietly moving less during the rest of the day.

Exercise truly shines when it comes to keeping weight off and keeping your body healthy. In the Biggest Loser follow-up study, the contestants who kept the most weight off six years later were the ones who had increased their physical activity the most. The same pattern shows up in the National Weight Control Registry.

Strength training deserves its own mention. Skeletal muscle is the largest site where insulin moves sugar out of your blood, so it acts something like a sponge or a sink. The more muscle you keep, the better your body handles sugar.

Exercise also makes your cells more sensitive to insulin and shrinks deep belly fat, often before the scale changes much.

Serve: the driver most plans leave out

Serve covers the parts of life that give you direction and resilience, which we group as success (your definition), engagement, relationships, values, and emotional agility. Emotional agility is the skill of noticing hard feelings without letting them make your decisions for you.

Serve matters because stress changes your biology. Chronic stress affects appetite, sleep, food choices, and the stress hormone cortisol. It can promote cravings and, in some people, patterns associated with fat building up around the middle. Stress also wears down the brakes described in Chapter 2, which is why a hard day so often ends with a snack you didn't plan.

Purpose and connection push in the other direction. People with strong relationships tend to live longer. Research on weight control also shows that people whose motivation comes from their own values, rather than from guilt or outside pressure, are more likely to keep weight off over time.

IN PLAIN ENGLISH: THE STEERING WHEEL

If sleep keeps your brakes in good shape and savor eases off the gas pedal, "serve" is the steering wheel. Your values decide where you're headed, and the people around you help you stay on the road when the brakes are tired.

How the four drivers work together

The four drivers work best together because each one makes the others easier. Better sleep reduces cravings, eating well gives you energy to move, and moving improves both your sleep and your mood, while a stronger sense of purpose helps you return to all three after a hard week.

Once this cycle gets going, healthy choices take less effort, because your biology starts working with you instead of against you.

This guide explains why the four drivers work. *The Breaux Medical Guide to Metabolic Health*, which clients receive, shows you how to put each one into practice with step-by-step plans.

COMMON QUESTION: "WHICH DRIVER MATTERS MOST?"

There isn't a single answer, because it depends on where you are now. For many busy professionals, sleep is the most overlooked driver and often the fastest to improve. The best starting point is usually the driver where you're weakest.

COMMON QUESTION: "CAN I EXERCISE MY WAY OUT OF A BAD DIET?"

It's very hard. A 30-minute run burns about 300 calories, which is less than a large bakery muffin. Exercise is essential for health and for keeping weight off, but food choices usually drive weight loss.

COMMON QUESTION: "DOES STRESS REALLY CAUSE WEIGHT GAIN?"

Stress doesn't add calories by itself, but it changes your hormones, your cravings, and your self-control. Over time, those changes make weight gain more likely and weight loss harder.

MYTH VS. SCIENCE

Myth: Losing weight is mostly about diet, so the other drivers are optional.

Science: Sleep, movement, and stress each change your hunger hormones, your cravings, and how your body stores fat. A diet that ignores them is working against your biology.

TRY THIS TODAY: THE DRIVER CHECK

Rate each of the four drivers from 1 to 5, where 1 means it needs a lot of work and 5 means it's going well. Your lowest score is your starting point. Write down one small action for that driver that you could take this week.

THE TAKEAWAY

You can't out-willpower your biology, but you can change the signals it receives. Sleep, Savor, Sweat, and Serve each help your thermostat, reward system, and brakes work in your favor, and together they make healthy choices easier to repeat.

CHAPTER 4

How Change Actually Happens

Chapter 2 explained why willpower fails, and Chapter 3 described the four drivers that actually move your biology. That leaves the question every reader asks next, which is how a person actually changes.

Most weight loss programs skip this question. They hand you a plan and assume you're ready to follow it. Research on behavior change says that assumption is wrong most of the time.

In the 1980s, a psychologist named James Prochaska studied thousands of people who changed hard habits on their own, without any program. He proposed that change is not a single decision, but something that moves through stages, and that a strategy aimed at the wrong stage tends to be poorly timed and ineffective. The stages are a useful working model rather than settled biological fact, and researchers still debate how sharply they divide.

His research also found something surprising. For most health behaviors, only about 20% of people are ready to take action at any given time. Roughly 40% are not thinking about change yet, and another 40% are thinking about it but not prepared to start. Those proportions are approximate, but they make the point that most programs are built for a small slice of the people who need them.

The five stages

Precontemplation. You're not planning to change in the next six months. You may feel defensive when the subject comes up, or simply tired of failed attempts.

Contemplation. You're thinking about change, but you feel torn. You can list every reason to start and every reason it won't work, and this stage can last years.

Preparation. You've decided, and you're getting ready to start within the next month.

Action. You've made changes within the past six months. This stage takes the most energy, and it's where most people either get support or quietly drop off.

Maintenance. You've held the change for more than six months. The work shifts from starting to protecting, and the table below shows what helps at each stage.

Stage	What it sounds like	What actually helps
Precontemplation	"This isn't really a problem for me."	Information, not pressure. Learn your biology and your numbers.
Contemplation	"I know I should, but I've tried and I don't want to fail again."	An honest pros and cons list. Connect change to your values.
Preparation	"I'm going to start next month."	A specific plan, a start date, and a coach or partner.
Action	"I've been doing this for two months."	Tracking, routines, and fast troubleshooting.
Maintenance	"This is just how I eat now."	Plans for travel, holidays, stress, and setbacks.

Why matching matters more than trying harder

Here is the most useful idea in this chapter: a plan that fails is often mismatched to your stage rather than proof of weak commitment.

If you're in contemplation and someone hands you a 12-week meal plan, you'll probably start it and quit within days. The plan wasn't wrong, but it was aimed at a stage you hadn't reached. On the other hand, if you're in the action stage and all you get is more information about why obesity is harmful, you'll be frustrated, because you already know.

Prochaska's research also showed what moves people between stages. To move out of precontemplation, the reasons for changing have to grow. To move into action, the reasons against changing have to shrink. Those are two different jobs, and they call for two different conversations.

Going around more than once is normal

Stage progress is not a straight line. Prochaska described it as a spiral rather than a circle, because most people cycle through the stages several times before a change sticks.

This is worth sitting with, because the biology from Chapter 2 makes cycling more likely. Your thermostat pushes back, life gets stressful, and you slip. In this model, a slip is not a return to the starting line, because each attempt teaches you something specific about what your plan was missing.

IN PLAIN ENGLISH: MERGING ONTO THE HIGHWAY

Think of learning to drive on a busy highway. Your first merge is nerve-wracking, and you might back off. The second time, you know what to expect. Nobody calls the first attempt a failure, because it was practice.

The missing ingredient in most programs

Here's what I find most striking about the research on weight loss. The Diabetes Prevention Program cut the relative risk of type 2 diabetes by 58%, and it did not use a secret diet or a special food. Participants met with a lifestyle coach, worked through a structured curriculum, set goals, tracked their own behavior, and got help solving problems week by week. The trial cannot separate out which piece did the work, but frequent human support was one important part of the package.

Reviews of health coaching studies find similar patterns, with improvements in weight, blood sugar, activity, and confidence. National screening guidelines now recommend that adults with obesity be offered intensive behavioral programs, and the programs that work best include many coaching contacts in the first year.

Most weight loss products skip exactly that ingredient. You can buy plans, apps, and even medications on your own, but programs with repeated contact, self-monitoring, problem solving, and ongoing support tend to outperform one-time advice.

This is why coaching is built into how we practice at Breau Medical, alongside labs, medical care, and medication when it's appropriate. A coach does not tell you what you already know. A coach helps you find your own reasons, create a plan that fits your actual life, and restart quickly when something goes sideways.

COMMON QUESTION: "WHAT IF I'M NOT READY?"

That's a normal and useful answer. Ready is a stage, not a character trait, so your next step is to learn rather than to start a program. Read Chapter 5, get your numbers, and let the facts do the work for a while.

COMMON QUESTION: "ISN'T THIS JUST ACCOUNTABILITY I COULD GET FROM AN APP?"

An app can remind and track, and that genuinely helps in the action stage. What an app can't do (yet?) is ask why last Thursday fell apart, notice that your sleep is driving your cravings, or adjust the plan when your labs or your life change.

COMMON QUESTION: "I'VE FAILED SO MANY TIMES. WHY WOULD THIS TIME BE DIFFERENT?"

Because each previous attempt likely stalled for a specific, fixable reason. Cycling through the stages is the normal path, not proof that you can't change. The useful question is not why you failed, but what your plan was missing.

COMMON QUESTION: "HOW LONG UNTIL A NEW HABIT STICKS?"

It varies more than the popular "21 days" claim suggests. In one study, new habits took a median of about 66 days to feel automatic, with a range from about three weeks to eight months. Longer is normal.

MYTH VS. SCIENCE

Myth: If you really wanted to change, you would just do it.

Science: Wanting is not the same as being prepared. Decades of research show that readiness moves through predictable stages, and that matching your strategy to your stage produces better results than pushing harder.

TRY THIS TODAY: NAME YOUR STAGE

Write down which stage you're in for one specific change, such as strength training twice a week. Then write two lists: the real reasons to change, and the real reasons not to. If the second list is longer, you're in contemplation, and your next job is to address those reasons rather than to start a program.

THE TAKEAWAY

Change happens in stages, and most people struggle because their strategy doesn't match their stage. Learn where you are, do the work that fits that stage, and expect to cycle through more than once. Lasting change rarely comes down to willpower or the perfect plan, because ongoing support is one of the most consistently useful ingredients in making it stick.

CHAPTER 5

What to Measure (and Why)

Imagine judging a whole movie by looking at a single frame. You might catch a smile or a frown, but you would have no idea where the story was headed. Many people treat their lab results the same way: they get one set of numbers a year, see that everything is marked "normal," and move on.

This chapter explains which measurements tell you the most about your metabolic health, in plain language, and why the direction of your numbers matters more than any single result.

Why "normal" isn't always enough

Most lab ranges are built from the average adult, and the average American adult is not metabolically healthy. By one strict definition used in an analysis of national data from 2009 to 2016, only about 1 in 8 U.S. adults had healthy levels across blood sugar, blood pressure, triglycerides, HDL cholesterol, and waist size.

Metabolic problems also develop slowly. Blood sugar often stays normal for years while insulin quietly rises to keep it there, so by the time blood sugar goes up, the problem may have been building for a long time. That's why a result near the edge of normal, or one that creeps up year after year, deserves attention even if it never gets flagged.

Blood sugar: A1c and fasting glucose

Your **A1c** reflects your average blood sugar over the past three months:

- Below 5.7% is considered normal.
- 5.7% to 6.4% is prediabetes.
- 6.5% or higher suggests diabetes.

About 1 in 3 U.S. adults has prediabetes, and most of them don't know it. A1c has limitations, because conditions such as anemia, kidney disease, and some inherited hemoglobin differences can distort it, and a diagnosis usually needs a confirming test.

Fasting glucose, a blood sugar test taken after not eating overnight, adds a second view. A fasting level below 100 mg/dL is normal, and 100 to 125 mg/dL suggests prediabetes.

Insulin: the early warning light

Insulin is the hormone that moves sugar out of your blood. When your cells stop responding well to insulin, your body may make more of it to keep blood sugar normal, and that pattern can begin years before blood sugar changes.

Some clinicians use a **fasting insulin** level, or a score called **HOMA-IR** that combines fasting insulin and fasting glucose, in selected cases. These are optional tools rather than routine screening tests, because insulin assays are not standardized across labs, results vary day to day, and major diabetes guidelines do not recommend them for the general public. If you and your clinician use them, track them at the same lab over time.

Triglycerides: a clue in your blood fats

Triglycerides are a type of fat in your blood, and high levels often travel with insulin resistance, a diet heavy in sugar and refined starch, or heavy drinking. A fasting level below 150 mg/dL is considered normal, and lower is generally better.

Many clinicians also look at your triglycerides divided by your HDL cholesterol. A higher ratio often points to insulin resistance, although thresholds vary by sex and ancestry. Read it alongside your other results rather than on its own.

ApoB: counting the trucks

Most people know their LDL cholesterol, but **ApoB** tells you something more useful. Every particle that can carry cholesterol into your artery walls carries one ApoB protein, so measuring ApoB estimates the number of those particles.

IN PLAIN ENGLISH: DELIVERY TRUCKS

Think of cholesterol particles as delivery trucks and cholesterol as the cargo. LDL cholesterol measures the cargo on the road, while ApoB counts the trucks, and the number of trucks is what drives the risk of plaque building up in your arteries.

People with insulin resistance (high glucose, high triglycerides) often have many small trucks, each carrying less cargo. As a result, their LDL can look normal while their ApoB is high.

Your ApoB goal depends on your overall heart risk, so it should be set with your clinician.

Lp(a): the inherited risk worth checking once

Lipoprotein(a), or Lp(a), is an inherited lipoprotein particle that raises the risk of heart attack and stroke. Your level is set mainly by your genes, so it usually changes little over your life.

About 1 in 5 people have a high level, and most have never been tested. Diet and exercise don't change Lp(a) much, but knowing your level helps your clinician decide how carefully to manage your other risks. One measurement is enough for many adults.

Your liver: the silent organ

Fatty liver disease affects about 1 in 3 adults, and it usually causes no symptoms until it is advanced. A liver enzyme called **ALT** can hint at a problem, but it can also look normal while fat is building up in the liver.

Your clinician can use a simple score called **FIB-4** to estimate your risk of liver scarring, which is different from measuring liver fat. It combines your age, two liver enzymes, and your platelet count, and it needs age-aware interpretation, since it performs poorly under age 35 and is read differently after 65.

Inflammation: hsCRP

A test called **hsCRP** (high-sensitivity C-reactive protein) measures inflammation in your body, and a higher level can refine your heart risk picture when it would change a decision. It is not a routine annual test, and because it rises temporarily with any infection or injury, an elevated result should be repeated once you are well.

Beyond blood work

Blood pressure. High blood pressure rarely causes symptoms, yet it is one of the strongest drivers of heart disease and stroke. A reading below 120/80 is considered normal. Home readings often give a truer picture than a single office reading, because many people's blood pressure runs higher at the doctor's office. The standard method is a validated upper-arm cuff, with two readings in the morning and two in the evening, for at least three days and ideally seven.

Waist-to-height. The string test from Chapter 1 checks whether your waist is less than half your height. It's a free, simple way to track belly fat, and a shrinking waist is often one of the first signs that your metabolic health is improving.

Body composition. Body composition tells you how much of your weight is fat and how much is muscle.

- **DEXA scan:** A low-radiation scan that measures fat and bone and estimates lean mass and the fat around your organs. Lean mass includes water, organs, and connective tissue, so it is not the same as muscle.
- **Smart scales:** Less accurate, because readings shift with hydration, but still useful for trends if you use them the same way each time.

Your measurement map

Use this as a discussion framework with your clinician rather than a universal screening schedule. How often you test depends on your risk and on whether the result would change your care.

Test	What it tells you	How often
A1c and fasting glucose	Your average and fasting blood sugar	Once a year, or every 3 to 6 months when making changes
Fasting insulin and HOMA-IR	Possible early insulin resistance	Optional, in selected cases, when it would change your plan
Triglycerides and HDL	Blood fats linked to insulin resistance	Once a year
ApoB	The number of particles that can cause plaque	Once a year, or more often if you're on treatment
Lp(a)	Inherited heart risk	Once in your lifetime
ALT and FIB-4	Fatty liver and scarring risk	Once a year if you have risk factors
hsCRP	Inflammation linked to heart risk	Once, when it would change a decision, and repeated if elevated
Blood pressure	Strain on your heart and blood vessels	At every visit, and at home if it runs high
Waist-to-height	Belly fat	Periodically, as a simple way to follow your own trend
Body composition	Fat and lean mass	Only when it would change your plan, as your clinician advises

A NOTE BEFORE YOU TEST

This chapter is for education, not medical advice. The right tests, goals, and timing depend on your health history and should be personalized with your clinician.

COMMON QUESTION: "MY LABS ARE NORMAL, SO AM I FINE?"

Normal is a good start, but it isn't the same as optimal. Check whether your numbers are drifting in the wrong direction over time, and whether your labs include the tests in this chapter.

COMMON QUESTION: "WHY HASN'T MY DOCTOR ORDERED APOB OR INSULIN?"

Routine care prioritizes tests with established population-level benefit. Fasting insulin is not standardized across labs, and ApoB, while not a new test, is not yet routinely ordered in many practices, though several major medical groups now support it in selected risk contexts. It's reasonable to ask your doctor whether these tests make sense for you.

COMMON QUESTION: "DO I NEED A DEXA SCAN?"

Not everyone does. A DEXA scan is most helpful in three situations: you're losing weight and want to protect your muscle, your BMI doesn't match how you look or feel, or you want an accurate starting point.

COMMON QUESTION: "HOW OFTEN SHOULD I TEST?"

For most people with normal results, once a year is enough. If you're making big changes or starting a new treatment, testing every 3 to 6 months lets you and your clinician see whether the plan is working.

MYTH VS. SCIENCE

Myth: If my LDL cholesterol is normal, my heart risk is low.

Science: LDL cholesterol can look normal while ApoB or Lp(a) is high, especially in people with insulin resistance. A fuller picture gives you and your clinician a better sense of your true risk.

TRY THIS TODAY: LINE UP YOUR NUMBERS

Find your lab results from the past two or three years and line them up side by side. Circle any number that has moved in the wrong direction, even if it's still in the normal range. Bring that list to your next appointment.

THE TAKEAWAY

One lab result is a snapshot, but a series of results tells a story. A1c, fasting insulin, triglycerides, ApoB, and Lp(a), along with your blood pressure, waist, and body composition, show where your metabolic health is headed. Catching the direction early gives you the most room to change it.

CHAPTER 6

When Medications Make Sense

If a patient had an underactive thyroid, nobody would suggest fixing it with willpower. If someone's blood pressure ran high, we wouldn't call the medicine a shortcut. Obesity is also a medical condition driven by biology, and for many people, medication belongs in the plan.

I want to be clear about where I stand. Medication is not the first answer for everyone, and it does not replace the four drivers in Chapter 3. It is a real tool that works on the same biology I described in Chapter 2. For the right person, it changes what is possible.

What these medicines actually do

Your gut naturally makes a hormone called GLP-1 when you eat. It tells your pancreas to release insulin, slows how fast your stomach empties, and signals your brain that you have had enough. The newer medicines activate that same receptor pathway and keep the signal going steadily, rather than for a few minutes after a meal. Semaglutide is a close copy of the hormone itself, while orforglipron is a small molecule that switches on the same receptor without copying the hormone. Tirzepatide acts on the GLP-1 receptor and on a second gut hormone receptor called GIP, which appears to make the effect stronger.

In plain language, these medicines work on the thermostat and the reward system from Chapter 2. Patients describe it as the food noise going quiet. The background chatter about what to eat next fades, and choosing a normal portion stops feeling like a fight.

Who they're for

For most of the adult obesity medications discussed here, the FDA has approved use in two groups:

- People with a BMI of 30 or higher.
- People with a BMI of 27 or higher who also have a weight-related condition, such as high blood pressure, prediabetes, high cholesterol, or sleep apnea.

Your clinician will also consider your health history, your other medicines, your goals, and your insurance.

What's available now

Medication	How it's taken	Average weight loss in studies
Semaglutide (Wegovy)	Weekly injection	About 15%
Tirzepatide (Zepbound)	Weekly injection	About 20%
Oral semaglutide (Wegovy pill)	Daily pill	About 14%
Orforglipron (Foundayo)	Daily pill	About 7% to 11%, by dose
Older medicines	Daily pills or a daily injection	About 3% to 10%

These averages come from different trials, doses, populations, and lengths of treatment, so they are not head-to-head comparisons and they cannot predict your own result. Bariatric surgery sits in a separate category, with average weight loss closer to 25% to 30% depending on the procedure.

The pills are the newest additions. The FDA approved the Wegovy pill in December 2025, and it reached pharmacies in early January 2026. Foundayo (orforglipron) followed on April 1, 2026. In their main trials, using the analysis that counts everyone including those who stopped treatment, the Wegovy pill produced about 13.6% weight loss over 64 weeks, and orforglipron produced about 11.2% over 72 weeks.

The older group includes phentermine, phentermine with topiramate, naltrexone with bupropion, orlistat, and liraglutide, which cost less, have longer track records, and still help some people.

The two leading injections have been compared head to head in adults with obesity and without diabetes. Tirzepatide led to more weight loss than semaglutide, at about 20.2% versus about 13.7%. The oral options trade injection-free dosing for differences in efficacy, dosing instructions, coverage, and cost. That trade matters, because the best medicine is the one you can stay on.

Benefits beyond the scale

Weight is not the only reason to consider these medicines. In a large trial of adults aged 45 and older who had established heart disease and excess weight but not diabetes, semaglutide lowered the relative risk of heart attack, stroke, and death from heart disease by about 20% over about three years, which meant a drop from 8.0% to 6.5% of participants having such an event.

Several of these medicines are also approved for other conditions. As of this writing, tirzepatide is approved for moderate-to-severe obstructive sleep apnea in adults with obesity, and semaglutide products carry approvals for specific liver and kidney conditions. Many patients also see better blood sugar, lower blood pressure, less joint pain, and more energy.

The honest trade-offs

No honest discussion stops at the benefits.

Stomach symptoms are the most common problem. They include nausea, constipation, diarrhea, and reflux, and they are usually worst right after a dose increase. This is why the dose should be raised slowly.

Less common risks include gallstones and, rarely, inflammation of the pancreas. These medicines are not safe during pregnancy. The labels also warn against use if you have a personal or family history of medullary thyroid carcinoma, a rare thyroid cancer, or of a genetic condition called multiple endocrine neoplasia type 2.

Lean mass deserves special attention. Some of the weight lost on these medicines is lean mass rather than fat, as it is with any weight loss. Lean mass is not the same as muscle, because it also includes water, organs, fat inside of organs and muscle, and connective tissue, so studies cannot tell us exactly how much muscle is involved. Resistance training, enough protein, eating enough overall, and tracking your strength are sensible safeguards, and they help preserve muscle and function. They matter most for older adults and anyone already frail.

Cost is a real barrier, though less than it used to be, and the same medicine can cost very different amounts depending on how you get it. Insurance coverage for weight loss treatment varies widely and usually requires approval first. Manufacturer savings cards help most if you have commercial insurance that covers the medicine. Both makers now sell direct to patients who pay cash, at a steep discount off list price, which is often the least expensive route when insurance won't cover treatment, and the newer pills have added lower-cost options. Prices and programs change often, so price your exact dose through each route before you decide. Availability and pricing described here reflect September 2026.

Compounded versions are advertised online at low prices. These are not FDA-approved products, and the FDA has warned about dosing errors and quality problems with them. Now that the shortages have ended, pharmacies may no longer produce these drugs in bulk as essentially copies of the approved products, though compounding for an individual patient can still be permissible in narrow circumstances. If you are considering one, ask your clinician why a compounded version is being used instead of an approved product.

What happens when you stop

This is the question I get most often, and the honest answer is uncomfortable. When people stop these medicines without another plan, the weight usually comes back. In one study that followed people after they stopped semaglutide, they regained about two-thirds of the weight they had lost within a year. Patients also commonly report that hunger and food noise return, and the thermostat from Chapter 2 goes right back to defending the old weight.

This is not a sign that the medicine failed. It is a sign that obesity behaves like other long-term conditions. Nobody expects blood pressure to stay low after stopping blood pressure pills, and nobody calls that a failure of willpower.

IN PLAIN ENGLISH: A TAILWIND, NOT A DESTINATION

Think of the medicine as a strong tailwind rather than a destination. It makes the work of the four drivers much easier, but it does not do that work for you, and protein, strength training, sleep, and stress skills are what you keep when the tailwind changes.

What's coming

More options are on the way. In trials, combination injections and a triple-hormone medicine called retatrutide have produced even larger weight losses. These remain investigational and in late-stage development, which means none of them should be purchased or compounded before approval. Your clinician can tell you what is actually available and appropriate for you today.

COMMON QUESTION: "ISN'T THIS CHEATING?"

It isn't cheating, any more than using insulin for diabetes is cheating. These medicines correct biology that is working against you. Your work on food, movement, sleep, and stress still matters, and most people find that work gets easier on treatment.

COMMON QUESTION: "WILL I HAVE TO TAKE IT FOREVER?"

Many people do stay on some dose long term, much like people stay on medicine for blood pressure or cholesterol. Some clinicians individualize maintenance dosing, but we do not yet have strong evidence identifying who can stop without substantial regain. This is a decision to revisit with your clinician, not a life sentence.

COMMON QUESTION: "ARE THEY SAFE LONG TERM?"

The GLP-1 drug class has more than two decades of clinical use, and semaglutide itself has been in use since 2017. The safety record so far is reassuring. The newest medicines have shorter track records, so regular follow-up with your clinician matters.

COMMON QUESTION: "WHAT ABOUT MUSCLE LOSS?"

Some lean mass is lost with any weight loss, whether from dieting, surgery, or medicine. Three habits help preserve muscle and function: enough protein, resistance training, and losing weight at a steady pace rather than a crash pace.

MYTH VS. SCIENCE

Myth: These medicines are for people who won't do the work.

Science: Most patients I see have already done enormous amounts of work, often for decades. These medicines lower the biological resistance that made all that work so hard to sustain.

TRY THIS TODAY: PREPARE YOUR THREE ANSWERS

If you are considering medication, write down three things before your next appointment. First, your latest numbers from Chapter 5. Second, the medicines and conditions you already have. Third, your honest answer to this question: what would I want this medicine to change about my daily life?

THE TAKEAWAY

Weight loss medicines work on real biology, not on character. They can lead to meaningful weight loss and lower the risk of heart, liver, kidney, and sleep problems. They also bring side effects, a cost, and the reality that stopping usually brings the weight back. Used alongside the four drivers, they are a tool. Used alone, they are only a tailwind.

A NOTE ON THIS CHAPTER

This chapter is for education, not medical advice. Medication, approval, and pricing information is current as of September 2026. Whether a medicine is right for you, and which one, is a decision to make with your clinician.

CHAPTER 7

Building Your Personal Health Strategy

By now you know that weight is a signal, that your body defends its weight with real biology, that four drivers move that biology, that change happens in stages, and that measurement and medication are tools rather than answers.

This chapter puts it together. A strategy is not a diet, and it isn't a burst of motivation in January. It's a small set of decisions you make once and then revisit as your life and your numbers change.

Step 1: Understand your biology

Guessing is expensive, and people spend years working hard on the wrong thing because nobody ever showed them their own data.

Start with the measurements in Chapter 5. Your goal is not a perfect report card, but a clear view of which direction your body is heading and what is driving it.

If your labs show insulin resistance, your plan will look different than if your labs are clean but your blood pressure is creeping and your sleep is short. The data narrows the work.

Step 2: Choose your drivers

You don't need to fix all four drivers at once, and Chapter 4 explained why trying usually stalls. Pick the driver where you are weakest and where you are most ready to act. For many busy professionals, that turns out to be sleep or strength training.

Then pick one specific action, attach it to a time and a day, and keep it small enough that a hard week won't break it. Chapter 3 explains why each driver works, and *The Breaux Medical Guide to Metabolic Health* gives you the step-by-step plans for all four.

Step 3: Decide on your tools

Medication is not the first move for everyone, and it is not a last resort for the weak. It's a decision based on your BMI, your health conditions, your history of previous attempts, and your goals.

The honest version of this decision sounds like a conversation rather than a sales pitch. What has already failed, and why? How much biological resistance are you fighting? What would you want a medication to change about your daily life? Chapter 6 covers what these medicines do and what they ask of you in return.

Step 4: Track your direction and adjust

Your body gives you feedback on three timescales. Weekly, watch your habits, your energy, and your sleep. Monthly, check your waist and your weight trend rather than a single morning's number. Every three to twelve months, your labs show whether the plan is actually changing your biology.

One rule keeps people sane here. Trends usually reveal the direction you're heading, so one bad morning on the scale means little, while six months of a rising A1c means a great deal. The exception matters too, because a single markedly abnormal result, such as very high blood pressure or blood sugar, needs attention right away.

Step	What you do	Where it's covered
1. Understand your biology	Get the right measurements and read the direction, not just the range	Chapter 5
2. Choose your drivers	Start with your weakest driver and one specific action	Chapters 3 and 4
3. Decide on your tools	Discuss whether medication belongs in your plan, and when	Chapter 6
4. Track and adjust	Review habits weekly, your waist monthly, and labs a few times a year	Chapters 1 and 5

THE METABOLIC DIRECTION CHECK

This is a reflection tool to bring to a conversation, not a diagnostic score. Answer yes or no to each question.

1. My waist is larger than it was five years ago.
2. My blood sugar, blood pressure, or triglycerides have drifted up over the past few years, even if they're still called normal.
3. I sleep less than seven hours most nights.
4. I do strength training fewer than two days a week.
5. I have lost and regained the same 10 or more pounds more than once.
6. I feel a clear energy crash in the afternoon most days.
7. A parent or sibling has diabetes, heart disease, or a stroke in their history.
8. I have never had my ApoB or my Lp(a) measured.

Any yes answers are worth raising with a clinician. They do not add up to a score or a probability, but together they point to whether your metabolic direction deserves a closer look now, while you still have the most room to change it.

Where to start

This is where I'll be direct about what we do at Breaux Medical, because the whole point of this guide is action rather than information.

The Baseline Assessment is where your strategy starts. We review your full history, order the measurements in Chapter 5, and interpret them together, including the direction they have been moving. We talk honestly about the four drivers, your stage of readiness, and whether medication belongs in your plan. Then we build a plan you can actually follow, with coaching built in.

When you begin, you also receive *The Breaux Medical Guide to Metabolic Health*, which turns each of the four drivers into practical weekly plans.

You don't need to be ready to overhaul your life. You only need to be ready to find out where you stand.

COMMON QUESTION: "WHERE DO I START IF I CAN ONLY DO ONE THING?"

Start with information, which means your measurements. For many of my patients, seeing their own data creates a clarity that vague advice never did, and it also points to which driver matters most for them.

COMMON QUESTION: "HOW LONG UNTIL I SEE RESULTS?"

Sleep and energy often improve within a couple of weeks, and blood pressure and triglycerides can move within a month or two. A1c reflects roughly three months of blood sugar, so give it a full quarter. Timelines vary widely, which is why direction matters more than the date.

COMMON QUESTION: "WHAT DOES A PHYSICIAN ADD THAT A COACH OR A PROGRAM DOESN'T?"

A coach helps you change behavior, and that matters enormously. A physician can also order and interpret the right tests, catch conditions that mimic or worsen weight gain, review medications that may be working against you, and prescribe and monitor treatment when it's appropriate. The combination is what makes a strategy medical rather than motivational.

COMMON QUESTION: "WHAT IF MY LABS COME BACK FINE?"

Good, and that's the best possible time to build a strategy. Prevention works best before a diagnosis appears, and a clean set of labs today gives you a baseline to compare against for the rest of your life.

MYTH VS. SCIENCE

Myth: I need to be more motivated before I can start.

Science: Motivation follows clarity more often than it leads it. Seeing your own numbers, understanding your biology, and having one specific next step will do more for your motivation than waiting to feel ready.

TRY THIS TODAY: WRITE YOUR "SO THAT" SENTENCE

Write one sentence that begins with "I'm doing this so that." Fill in something concrete and personal, such as keeping up with your kids, traveling without knee pain, or avoiding your father's heart attack at 58. Keep that sentence somewhere you'll see it, because it will outlast any diet.

THE TAKEAWAY

A strategy replaces guessing with four decisions: understand your biology, choose your drivers, decide on your tools, and track your direction. None of it requires perfection, and all of it works better with a partner. The most valuable thing you can do this month is find out which direction your body is heading.

CONCLUSION

Jordan, Nine Months Later

Jordan finally got a full picture, and the picture explained a lot.

Fasting insulin was high, even though blood sugar was still called normal. The A1c at 5.9 sat in the prediabetes range. LDL cholesterol looked fine, but ApoB was well above goal, which meant far more plaque-carrying particles than the standard panel suggested. The waist measured more than half of Jordan's height. A body composition scan showed lower lean mass than expected, which fit the broader pattern after three rounds of weight loss and regain.

None of it was a surprise once we looked. All of it had been developing for years, quietly, behind the word "normal."

Then came the more useful conversation. Jordan wasn't in the market for another 12-week plan, and such a plan would have failed like the last three. Jordan was still weighing whether a different approach was even worth the effort, which is contemplation rather than action. So we started with information and one decision instead of a full overhaul.

The weakest driver was sleep, so that came first, with a fixed wake time and a real wind-down. Two strength sessions a week went on the calendar, because muscle was the piece every previous attempt had ignored. Protein anchored each meal, which made the evening snacking fade on its own.

Ninety days later, sleep was up by an hour, the afternoon crash was gone, and the waist was down an inch and a half. Then progress stalled and hunger climbed. Rather than treating that as a character problem, we treated it as biology, which is what it was. Jordan started a GLP-1 medication with a clear plan to protect muscle, and kept lifting and eating protein throughout.

At nine months, the numbers told a different story than any scale ever had. The waist was down four inches. A1c was 5.5. Fasting insulin had dropped by half. ApoB was at goal. Weight was down 22 pounds, which was less than the first diet had produced in half the time, and it was the first time the weight had come off while strength was going up.

The difference wasn't willpower. Jordan had plenty of that already, and had spent years spending it on the wrong things. The difference was a strategy that matched the biology and the stage.

The through line

Let me leave you with the argument of this guide in one place. What your fat is doing matters more than what you weigh. Your body defends that weight with hormones, brain circuits, and metabolic changes that no amount of grit can talk out of it. Four drivers change the signals that system responds to: sleep, savor, sweat, and serve. Change happens in stages, and matching your strategy to your stage beats trying harder. The right measurements reveal your direction years before a diagnosis appears, and medications are real tools for real biology, neither a shortcut nor a last resort. A strategy built on your own numbers, revisited over time, is what turns all of this into results.

There is one more thing I want you to take with you. You are not broken, and you are not starting from zero. Every attempt you've made taught your body and your mind something, and every one of those attempts happened without the information in this guide.

You cannot change your genes, your age, or the food world you live in. You can change the direction your body is heading, and you can start with a single conversation and a clear set of numbers. That's the part I'd like to help with.

YOUR NEXT STEP

The Baseline Assessment

Everything in this guide points to one question: which direction is your body heading?

The Baseline Assessment is where we answer that together. It is the starting point for care at Breaux Medical, and it is built to replace guessing with data and a plan.

What it involves:

- **A full history.** We look back at your health story, your previous attempts, the medications you take, and what has and hasn't worked for you.
- **The right measurements.** We order and interpret the tests in Chapter 5, including blood sugar, insulin, blood fats, ApoB, Lp(a), liver markers, and body composition, and we read them as a direction rather than a single snapshot.
- **An honest conversation.** We talk through the four drivers, where your readiness actually sits, and whether medication belongs in your plan.
- **A plan you can follow.** You leave with specific next steps, and with coaching built into the care rather than sold separately.

When you begin, you also receive *The Breaux Medical Guide to Metabolic Health*, which turns each of the four drivers into practical weekly plans.

You don't need to be ready to change everything. You only need to be ready to find out where you stand.

Start at breauxmedical.com.

Breaux Medical is a multi-state, virtual-first longevity medicine practice that complements traditional, insurance-based care. It does not bill insurance for its services, but HSA and FSA dollars may apply.

ABOUT

Breaux Medical

Breaux Medical is a multi-state, virtual-first longevity medicine practice that complements traditional care. The practice was built to do what a 15-minute visit cannot: slow medicine down, look at the whole person, and build a plan before a diagnosis appears.

The approach rests on three ideas. Care should look back for understanding, honoring your history and your lived experience. It should look ahead with anticipation, finding risks early instead of reacting to crises. And it should look within for motivation, because lasting change comes from your own reasons rather than someone else's instructions.

In practice, that means longer visits, deeper measurement, coaching alongside medical care, and a clinician who knows your story.

Barry Breaux, Jr., MD, MBA

Dr. Breaux is a board-certified internist and the founder of Breaux Medical. He is also board certified in obesity medicine, lifestyle medicine, and culinary medicine.

He earned his MD and MBA at Columbia University and his AB at Harvard College, and he completed his internal medicine training in 2016 at NYP-Columbia. He practiced in traditional settings before leaving to build a proactive, relational care model focused on healthspan, which means the years you live well rather than simply the years you live.

He writes *The Breaux Brief*, a newsletter on the culture and science of proactive healthcare, and he leads Longevity For The People, a community health workshop series based in Oakland with in-person and digital programming.

Learn more: breauxmedical.com

Use of Artificial Intelligence

Artificial intelligence tools were used to assist with literature discovery, fact-checking, reference review, and editorial refinement. All clinical interpretations, recommendations, and final wording were reviewed and approved by the author, who takes full responsibility for the accuracy and content of this guide.

Selected References

This guide is written in plain language. The key scientific claims in it are grounded in published research and current clinical guidance, and the sources below are grouped by chapter for readers who want to go deeper. Medication and regulatory information is current as of September 2026.

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Clinical note: This guide is general education, not personal medical advice. Decisions about testing, treatment, and medication should be made with a qualified clinician.