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not only from a laboratory but also from policy, education, and advocacy. Indeed, a handbook designed to educate doctors on obesity recommended a notably nonmedical course of action, calling for "major changes in some aspects of western culture" (Hoppin & Taveras, 2004, Conclusion section, para. 1). Cultural change may not be the typical realm of medical professionals, but the handbook urged doctors to be proactive and "focus [their] energy on public policies and interventions" (Conclusion section, para. 1).

The solutions proposed by a number of advocacy groups underscore this interest in political and cultural change. A report by the Henry 3. Kaiser Family Foundation (2004) outlined trends that may have contributed to the childhood obesity crisis, including food advertising for children as well as

a reduction in physical education classes and after-school athletic programs, an increase in the availability of sodas and snacks in public schools, the growth in the number of fast-food outlets . . . , and the increasing number of highly processed high-calorie and high-fat grocery products. (p. 1)

Addressing each of these areas requires more than a doctor armed with a prescription pad; it requires a broad mobilization not just of doctors and concerned parents but of educators, food industry executives, advertisers, and media representatives.

The barrage of possible approaches to combating childhood obesity—from scientific research to political lobbying indicates both the severity and the complexity of the problem.

Brackets indicate a word not in the original source.

A quotation longer than 40 words is indented without quotation marks.

The writer interprets the evidence; she doesn't just report it.

The tone of the conclusion is objective.