Health Inequities in Obesity Care

CMEO Podcast Transcript

Monica E. Peek, MD, MPH, MS, FACP:

Hello and welcome to a very special podcast that was part of a series I'm leading on diversity, equity, and inclusivity with CME Outfitters. Today's CME podcast is entitled *Health Inequities in Obesity Care*. Today's program is supported by an educational grant from Johnson and Johnson. I'm Dr. Monica Peek, and I'm a professor of medicine and the associate director at the Chicago Center for Diabetes Translational Research. I'm also the Executive Medical Director of Community Health Innovation and the director of research at the MacLean Center for Clinical Medical Ethics at the University of Chicago in Chicago, Illinois. I'd now like to welcome two wonderful guests, Dr. Fatima Cody Stanford, and Miss Nijya Noble.

Fatima Cody Stanford, MD, MPH, MPA, MBA, FAAP, FACP, FAHA, FAMWA, FTOS:

Hi. My name is Dr. Fatima Cody Stanford. I'm an obesity medicine physician-scientist at Massachusetts General Hospital and associate professor of medicine and pediatrics at Harvard Medical School here in Boston, Massachusetts. I'm also one of the top-sighted physicians in obesity, ranked number 20 of over 320,000 around the world. I'm delighted to be here with you today.

Nijya Noble, MS, EDS, LD:

Hello, everyone. My name is Nijya Noble. I'm a registered dietician and fitness instructor and owner of NK Fitness and Nutrition, where host a private practice in Columbus, Ohio, and Augusta, Georgia.

Monica Peek:

I am so excited to have you both joining us today, really looking forward to our discussion and your expertise. I want to remind our audience at this CME podcast is a continuation of our initiative to address unconscious bias, health disparities, and racial inequities. We're building a comprehensive library of educational activities addressing these very important issues, and today's activity continues the discussion in obesity. The titles of the activities in this series are on the slides and the links are in the images. Simply click on the images to review any of these programs.

If you participate in at least three of the programs in our D&I Hub, you'll also be eligible to receive a digital badge demonstrating your commitment to education on diversity, equity, and inclusivity. Now it would be a disservice if we did not take a moment to discuss how we got here and have some framing for our work today. So as we begin to address obesity disparities, I just want to touch on some foundational points regarding historical racism and what we've done previously in our programs to discover these topics in depth. And all of these programs can be found in our D&I Hub, but what we always want to start with is the origin in thinking about structural racism and structural inequities and how they disproportionately distribute the social determinants of health among racialized minorities.

Monica Peek:

So right now, as we're thinking about health systems addressing these social determinants of health, we have to recognize that many of them are driven by racism and structural racism inequities, and so that they are more likely to exist within populations that are Black and Brown within communities that are Black and Brown and that those communities themselves have the physical places are more likely to have physical environments as far as the built environment, what is physically structured, social environments, and even the natural environment as far as the water, the air, the natural resources not be as healthy.

So we think about the Flint water crisis and other aspects, neighborhoods being more closely located to toxic waste dumps, et cetera. So the structural racism impacts how people live, work, and play in those environments. It also impacts the healthcare systems where they go and receive care and impacts the healthcare providers in those systems as far as implicit bias. So when we think about what happens as it impact or indirect effect of structural racism, we start to see the health impacts. We know that we can directly see things like increased mental health sequelae such as depression, anxiety, PTSD (post-traumatic stress disorder), et cetera. But we also start to see pathophysiological changes in the body. The chronic stress leads to changes in the HPA (hypothalamic-pituitary-adrenal) axis, autonomic dysfunction, elevated cortisol, all of the things that lead to myriad of chronic diseases that are disproportionately present in our communities of color.

Also, the implicit biases that providers have then begin to manifest in behaviors so that we begin to see differences in the quality of care or deviations from standard of care within health systems between White populations and non-White populations. We then have long-term effects between the kinds of healthcare that's delivered to vulnerable populations to marginalized populations, and the increased burden of health that those populations have as a direct function of structural racism. So this mismatch, we all witnessed with the COVID pandemic where we saw racialized minorities populations with higher amounts of chronic comorbid diseases that puts them at increased risk for disease, living in communities that themselves were increased place-based risk for infection, and having to go to hospital set may or may not have been optimally able to service them and having some reticence to sometimes receive care or to have vaccinations at these institutions because of historical distrust.

So we have to think about this larger framework of structural racism and how it has affected so many aspects of our populations and have contributed to disparities. With that framing that we now want to jump in and specifically think about our disease today, which is obesity. So let's get started with thinking about our program, which is to analyze the influence of unconscious bias, health disparities, and health inequities on obesity care. That's our learning objective for today's program. So, Nijya, I'm going to start with you and ask you to give us a snapshot of how obesity affects marginalized people and communities both globally and in the United States.

Nijya Noble:

Absolutely. Within the United States, obesity has tripled. We have seen these numbers increase in the communities of color, and that's where a major concern, and this is a concern because it affects those obesity-related diseases such as heart disease, cancer, diabetes. Also, we are seeing large numbers within our children, which play a major role within our community. A lot of the programs that we are starting to set affect those of color and then starting with our children with programs, with nutrition education being a prevalence for obesity to help in management of activities and develop programs for these communities to understand both globally and in the United States. We are, as dieticians, having some new programs to tackle this head-on with seeing this increased number of obesity.

Monica Peek:

Yeah. The prevalence and the epidemiology has been astounding, and it's really important that we get ahead of this curve. Fatima, we know that obesity is a significant problem. Can you tell us about what fuels this epidemic or this pandemic now?

Fatima Cody Stanford:

Yeah, absolutely. One of the key things I want to do as we get into looking at these equity issues surrounding obesity first is to look at the racist origins of body mass index. So for those of you who are unaware of BMI or body mass index was actually derived from a Belgium statistician by the name of Adolphe Quetelet. Then 1800s, he sought to determine what normal weight status was for Belgium White male soldiers at the time. This became the basis for what we see for BMI today. It also became the basis for eugenics. Sir Francis Galton decided to determine what was considered to be desirable with regards to reproducibility, with regards to immigrant status, racial ethnic minority status, socioeconomic status size. These became the basis of what we see in Nazi Germany, which obviously did not turn out so well.

In the 1930s and 1940s, the Metropolitan Life Insurance Company then decided to determine what was ideal body weight for White men and women who were insured by the company. That's what has catapulted into what we use here in the US around the world for weight and weight status. Now you'll notice what I said was BMI was derived from statistician back in the 1800s actuarial table data in the 1900s. And that has nothing to do with medicine or science yet it is how we define one's weight status today. So I do want to give the historical context of why this is problematic. Now when we get into obesity, which is a chronic multifactorial, relapsing, remitting disease, we have to understand the complexity of it.

Fatima Cody Stanford:

There are factors that are inside of a person that can lead to someone having the disease of obesity and factors outside of a person. There are things that increase one's intake, things that decrease how much one is able to burn, and then those things that affect both intake and expenditure. There's a wide variety of factors. Everything from biological or medical reasons why someone may struggle with weight, food and beverage, behavioral and environment, maternal and developmental, social, psychological, economic, and then environmental pressures on physical activity. So let's talk about some factors that are inside of a person that may lead to a person having this disease of obesity. Things that may increase once intake is hyperreactivity to environmental food cues. So you pass by that pizza place and you immediately notice it or you maybe smell it a half mile away. That's a hyperreactivity to that environmental food cue.

You can imagine if it takes you longer to feel full, then that's going to make you have a propensity to eat more. Disordered eating can be definitely something that increases intake, things that decrease expenditure, things like the gut microbiota. What do I mean by that? That's the bacteria in one's gut. We do know that the bacteria in the gut of those are lean versus those that have obesity differ quite drastically. So much so that universities around the world, including here at Mass General, we're doing studies to take the gut microbiota from those that are lean and place it in those that have obesity. And we are seeing weight shifts with just that minor change. Thermogenesis, which is how much the body burns at rest, and with activity a lot of that is genetically determined. Then obviously, if you are physically disabled, unable to move your body fully, that will decrease how much you're able to burn.

Things that increase intake and decrease expenditure are things like genetic and epigenetics. It's at this point that I paused to let you know that weight is more heritable than height. You're like, "What did she just say?" So I'm going to say it again. Weight is more heritable than height. We do know if parents have obesity, there is a 50% to 85% likelihood that their child will have obesity even with optimal diet, physical activity, stress management, and the like. Age-related changes are particularly important as we look at things that increase intake and decrease expenditure because there are three main times in a woman's life where we may see major weight shifts. That's at the onset of menses, at pregnancy, whether or not that leads to a viable child, et cetera, and then at menopause where we see a decline in estradiol and we go from having a gynoid distribution of weight, gynoid meaning weight in the hip, buttock, and thigh region to having an android.

No, I'm not talking about the phone, we're talking about a male-like distribution where adipose or fat is carried more centrally. Then mood disturbances like depression and anxiety can increase intake and decrease expenditure. Now let's look outside of the person. We focused on inside of the person, and we want to go outside of the person to see what we're seeing there. Things that may increase intake or things like environmental or chemical toxins. Dr. Peek started with addressing some of these as we look at the global issues with inequities outside of obesity, and we also see this within obesity. Pervasive food advertising and then large portion sizes can increase one's intake. Things that decrease expenditure, things like the built environment is the area that you live in conducive to moving and things of that sort. Sedentary time, we're sitting here talking to you not moving, that will decrease our expenditure. Then labor-saving devices, these are things like your dishwasher, washing machine, and dryers. Things that we do use to make sure that we go about our day at a more expeditious fashion.

Fatima Cody Stanford:

Things that increase intake and decrease expenditure are stress. I'm going to pause here because also Dr. Peek mentioned the COVID-19 pandemic. One of the key issues that people recognize is that people did gain weight during the pandemic. We presume this was all due to dietary consumption and inadequate physical activity, but I am going to posit a new theory and that is stress went up significantly across all racial ethnic groups, across all socioeconomic groups here in the US and around the world. What we do know is that when stress goes up, storage of fat goes up. We store more adipose when we are in either acute or chronic stress, but the more chronic stressors i.e., the COVID-19 pandemic lead to a higher propensity to accumulation of adipose and weight. Weight cycling, which is those people that jump on this diet and then they come off or this activity program and stop that is really problematic because it ends up leading to higher weight status over time.

Then we already touched on this briefly, maternal and paternal obesity. If you are born to parents that have obesity, unfortunately, this dramatically increases your likelihood of having the disease. We have to recognize this, particularly, as we're dealing with 42.4% of US adults with this disease in over 20% of our children here in the United States.

Monica Peek:

We can always see that when we look at family photos. We notice that people not only look alike in their face, but we think... They all have a similar body type. So we certainly can understand what you said. It's more inheritable than your, what you said, your height?

Fatima Cody Stanford:

Weight is more inheritable than height. Lot of people, if you look at it in pediatrics, particularly, I'm going to put on my pediatrician hat and take off my internist hat for a second, we can calculate mid-parental height, right? We say, "Okay, well, this is dad's height, this is mom's height." Then we try to estimate what the height of an individual will be based upon those metrics. What I do when I'm providing care for my pediatric patients is I also look at mom and dad's weight because when I'm dealing with a child that's coming in with obesity and I see them as early as age two, I recognize that the two-year-old that's coming in hasn't had many environmental influences that have led to them having their obesity and being two standard or three standard deviations above normal. It is often what they're getting from their parents.

That's extremely important because a lot of people just blame it on what the parents are feeding them or that they're not exercising, not recognizing that it was just the recipe that they had that made them. I'm going to pull out dogs here. You guys are like, "What is dog? Where is she going with this?" But let's look at it. If we were to mate two bulldogs together, what are you going to get? A bulldog, short, stout, round dog, regardless of how much it weighs. Then if we were put two chihuahuas together, that's going to be a nice little lean dog. Now if we put a chihuahua with a bulldog, I have no idea what that would look like, but you can imagine that that's going to look a bit different. I don't want to think of us as dogs, but people understand dogs and different breeds, and those are two very recognizable ones. You can imagine that that's the genetic material that that person is getting. So that reflects in the offspring.

Monica Peek:

How do parents take that information that you give them about weight as opposed to height? Because I've never had my pediatrician tell me about that for my kids. I think it's really fascinating. What do they say?

Fatima Cody Stanford:

Well, then I put on my adult hat. I'm being an internist and a pediatrician helps out here because often when they are bringing in their child for excess weight, they themselves also are struggling. So I make it a family affair, and I say, "Look, this is not your fault. We're not going to blame you for this, but my goal is to help you get to the happiest, healthiest weight for you." So I began to not only treat their child, their two, three-year-old child, I also began to treat them. Then often what happens, the grandparents decide to see me too. So in many situations, I'm taking care of the child, the parent, the grandparent, and in a few situations, even the great-grandparent. Seeing that high transmissibility of this disease tackling it, but then trying to make it better for the offspring of that child so that we can optimize their health preconception.

Monica Peek:

That's fascinating. Like everyone being focused on the health of the next generation motivates everyone to do better.

Fatima Cody Stanford:

Yes, absolutely.

Monica Peek:

That's a great hook. This is wonderful. Thank you so much. We know that we have an obesity pandemic, you've given so much for us to think about it, about all the contributors, and we know that some of the things that contribute to it. Nijya, what are some of the main steps that one should take in assessing a patient with obesity?

Nijya Noble:

When we talk about assessment, some of the things we answered previously, but one thing I want to highlight is lifestyle and nutrition assessment. What I find when we talk about history and what parents were doing and grandparents and children is that nutrition assessment, we find there's a history of no knowledge of, "What can I have access to? What can I create? My grandmother did not have these fruits or vegetables. I've never seen these before. How can I use that? I did not know this affected diabetes. I did not know this was the reason that I'm gaining weight." So really seeing what is going on when we talk about that assessment, we do the weight, we all come in and do the weight, the height every time that calculates the BMI. But really listening and having that patient encounter and looking at... We know that nutrition plays a major role.

Nijya Noble:

Also, lifestyle, getting things moving, you're sitting all day at the job. We have to address that. How can we get things going? We really like to look at and sit down. We talk about assessment. I go from what are we doing now to what you did in the past and years ago? As we mentioned, we hear a lot of history that, "Okay, my grandfather had diabetes and he was fine and he ate pork chops every day and he had all the sugar within his drink." So how can we translate to, "Okay, but this is now, and here are some things that we're seeing and how does this affect you?" We talk about children who mentioned pediatrics, parents concerned that their children are gaining weight and do not eat vegetables and want to make sure they lead out as an example. So that full assessment as we talk about the whole household, the family, the lifestyle of really seeing that these things, all we know, the activity levels, the nutrition that really affects obesity and how as we assess, what can we do within that, how can we refer out, how can we also identify the risk for cardiovascular disease and diabetes and really seeing in that aspect.

I know we always do the weight and BMI, I hear that a lot within that. But one thing I try to add when being in the hospital or outside of hospital is really, let's get that nutrition assessment and let's get that lifestyle assessment because we know these changes really play a role in how we can have success in tackling obesity and how we can see some changes within that lifestyle realm along with that medical realm if we need medications and things like that. But those are some assessments that I'm really passionate about adding and making sure getting involved as a practice.

Monica Peek:

Great. Fatima, you had published an article a few years ago that suggests that the current BMI scale may not be an accurate way of measuring obesity for all individuals. And you had alluded to that earlier in your conversation. Can you explain a little bit of that?

Fatima Cody Stanford:

Absolutely. If we look at the current BMI charts, we know that a person is considered to have underweight if their BMI is less than 18.5, they're considered to be of normal. I'm going to put that in quotes. "Normal" weight status if their BMI is between 18.5 and 24.9. Persons considered to have overweight. Notice how I'm saying that I'm not using the word, overweight person. We want to use people first language to respect this marginalized group of individuals, those with obesity. Person with overweight would be a BMI of 25 to 29.9, and then we get into our three classes of obesity, class I, class II, class III, what we consider to be mild, moderate, severe. Mild obesity being classified as a BMI of 30 to 34.9, moderate a BMI of 35 to 39.9, and then those with severe obesity of BMI greater than or equal to 40. That's the metrics that we use, Dr. Peek. What I'm sought to determine was that I had noticed that we had already shifted the scale for Asian populations.

Fatima Cody Stanford:

Actually, the cutoffs for obesity are lower for Asian populations because we see a higher risk of metabolic diseases like type two diabetes at a much lower BMI. In 2004, those cutoffs were determined to be much lower. The cutoff for obesity ended up being a BMI of 27, which is obviously much less than the 30 that I mentioned earlier, which is considered to be when we're getting into class I or mild obesity. So I thought it was interesting that we looked at Asian but not looked at the major racial-ethnic groups here in the United States, particularly, as it related to chronic disease. So I use the National Health and Nutrition Examination Survey, and we pooled together all of the data through 2018 to look at Black men, Hispanic men, and White men, and then to look at Black women, Hispanic women, and White women and determine if the BMI cutoffs, particularly as we looked at chronic diseases associated with obesity, particularly high blood pressure, high cholesterol, diabetes, or greater than two of these risk factors to determine, "Hey, what is the BMI cutoff?"

Interestingly enough, for all men, whether you're Black, White, or Hispanic, we saw the BMI shift down across the board below 30, usually somewhere between 28 and 29. For women, in general, we saw it drop. For Hispanic women, the average was 29 and for White women 27. But interestingly enough, for Black women, the group two, which the three of us belong, we saw a shift up. The BMI cutoff actually shifted up to 31. Now what's interesting about that is that the group known to have the highest rates of obesity is indeed Black women. Over 80% of us have overweight and obesity. But I wanted to really delve deep and decide like, "Hey, what does this mean for us?" Despite all of that, I've already talked about the flaws of BMI. So I want to recognize that as we think about going beyond BMI and really getting into understanding the entire weight history of an individual.

So when I'm seeing a patient for the first time, whether they're one of my pediatric patients or one of my adult patients, I want to ask about the history of weight gain or loss over time. I really want to detail previous attempts at weight loss because often people will tell me, "Hey, Dr. Stanford, I know how to lose weight. I lost 100 pounds here." I don't really care about that acute loss.

This is a chronic relapsing, remitting, multifactorial disease, so I care about sustainability. I want to look at what we can do that we can sustain over the life course. That's looking at things like Nijya noted, which are things like dietary habits and physical activity. How do we get the person to do the things that they enjoy and sustain them over the life course? That family history of obesity is extremely important. We want to look at those medical conditions and or medications that actually may lead to weight gain. Medications like lithium, Depakote, Tegretol, Celexa, Cymbalta, Effexor, Paxil, Ambien, trazodone, Lunesta, gabapentin, glyburide, gliclazide, glimepiride, metoprolol, atenolol, propranolol, just to name the ones I wanted to tell you guys at that very moment.

Then we wanted to get into the social determinants of health and really looking at the financial resources available, what's in the background, what's in the neighborhood, how is this person using those to then define how they're thinking about the health of those environmental factors.

Monica Peek:

Really, really important because so many of the target population that we're thinking about has many of the comorbid conditions for which we treat these medications. Nijya, can you talk a little bit about food security, why that's a problem, and how that relates to obesity?

Nijya Noble:

Absolutely. It's a major problem. One thing that we've seen when I was involved in the community is that when we went out to the community, we offered programs, we offered free fruits and vegetables. One example, there were golden cherries. I don't know if you guys know anything about golden cherries. They're expensive. Okay? We gave them for free and people did not select them. They did not know what were. What we found there was a lack of education of really understanding. So we started adding how do we prepare these items. Here's free food. We're thinking everyone's going to take fruits and vegetables, but they've never seen them before, did not know what to do with them, did not know how to prepare. So adding those to it.

Also, we learned going into these communities, they don't have access to it. There's no public transportation to reach these items, no way to walk to reach these items. So when we talk about go eat fruits and vegetables, but what are fruits and vegetables? You'd be surprised. We don't always know that. "Where can I find these? I only have a gas station around the corner and there's only a banana, a rotten banana at times. Is a can, okay?" What we found is that we're really lacking that education that plays a role in understanding and how we can tackle obesity and really understanding the things, the availability, what is around you, but that education... We found that as we started educating, creating those classes, and understanding more likely to try these different fruits and vegetables that play a role, try and understand what is affecting those things such as cardiovascular disease, diabetes.

So it's really great to understand that there are food insecurities in the United States because sometimes we forget that. We think that we have access to everything, but that is not always true. That was just really something that we've started to hone in on we talk about the impact on obesity.

Monica Peek:

Yes. Particularly, because a lot of people with food insecurity fall into habits of feast or famine. For people with diabetes that can lead to episodes of hyperglycemia leading to readmissions, or hypoglycemia leading to hospitalizations. These sort of highs and lows of blood sugars can impact their health and lead to overall worse control. What's interesting is that African Americans, not that many generations ago were primarily farmers because we have the history of slavery. So it did not take too many generations for us to suddenly know nothing about the land, nothing about plants and vegetables, and like, "What is this thing?" That was something that we knew how to sustain ourselves on the land. With the great migration and moving into cities, it didn't take very many generations for us to lose that common communal knowledge about food and preparation and how to take care of our families. Now that's something that we're going to have to gain back and it's an ironic thing within our community. What are some of the tools that you use to address poor nutrition in the patients that you see?

Nijya Noble:

Some of the tools I use as one as listening. When we go about nutrition education, go in a non-judgemental way. A lot of times, I don't want to see, "You're going to take away my favorite things, my food." Understanding that there are cultural and ethnic appropriate nutritional plans, really identifying the things that you eat every day, the things that are culturally for you, it can be acceptable within a healthy lifestyle and how we can identify that. Also, including more plant-based programs. A lot of times when we hear plant-based, everyone thinks, "I have to eat fruits, and then I can't have anything else." Really understanding, looking at in a nonjudgmental way, how we can have these small changes that are sustainable but include cultural items but in items that we also enjoy and have access to.

Monica Peek:

Great. Then what about physical activity and exercise? This is really your wheelhouse, Nijya. What can you tell us in terms of its role in managing obesity?

Nijya Noble:

It plays a major role in managing obesity. We know it affects everything such as diabetes, cardiovascular disease risk, really, I say incur daily, daily, daily activity. We talk about this so much and we work from home, we order our groceries from home. We are not getting enough daily activity. So I really start honing in on daily activity and then including exercise, but also looking at environmental. I had a bad habit of saying just go on a walk. Then I find clients say, "Well, I can't walk in my neighborhood." So really understanding what we can do to increase that daily activity and help those. Using tools such as activity counters and how you can get daily activity when going to the store, whether you are working at home or being out and about and really being able to set realistic expectations, excuse me, when it comes to exercising.

Monica Peek:

Now I will say I haven't seen the inside of a grocery store in probably two or three years because Instacart is there, the pandemic. I'm like, "Oh, my gosh, this is so convenient." Once I started... But walking up and down those aisles, that was steps. I don't have those steps anymore. So you're right, just the activities of daily live living, going to the car, and then walking to your place of employment. Well, when we're working from home, that may be walking from your bed four feet to... So there's a big change. Thank you for thinking about helping us refocus on what we may have lost with the pandemic and how we may want to readjust our lifestyles to reincorporate exercise.

Monica Peek:

I want to turn into a different direction now and think about racial and ethnic disparities and implicit bias and talk a bit about that. We know that racial inequities are super pervasive in the US medical care system. There's just a very large body of literature around that and that provider interactions with patients of color that they're less patient-centered. There are fewer requests for patient input about treatment decisions and that equitable medication uptake and utilization amongst racial, ethnic, and socioeconomic groups that have limited income, et cetera, that we need more of that. Many people may have heard of the implicit bias test that was developed out of Harvard. So you can test your own kinds of implicit bias that you may have at Project Implicit. The website is there.

It just helps us to have a better understanding of those subconsciousness biases that we may carry at about different populations of people. Fatima, you see many patients who are fighting the disease of obesity. One of the things that we know is that providers have a lot of bias when they do the implicit bias tests against persons with obesity. So what are some of the tips and pearls that you use in discussions with your patients and how do we ensure that all patients who have obesity and overweight are engaged and treated equitably?

Fatima Cody Stanford:

Well, I love this question. I really delve a lot into bias with my patients and really want my voice to be heard because I really see that this is a major issue and let's just talk about how big the issue. We know that physicians have a 79% to 90% likelihood of having bias towards those with excess weight. So 79% to 90% of us as doctors have that. Now I'm not going to let our dieticians and other healthcare providers off because these groups also have high levels of bias, not quite as bad as physicians, but these are tremendous levels of bias, but who are the people supposed to see when they have obesity? They're supposed to see us as physicians, they're supposed to see the dieticians, they're supposed to see all-

Monica Peek:

And a safe welcoming space.

Fatima Cody Stanford:

Exactly. But it's not. What I hear from people is that they don't want to come and see us as doctors, dieticians, et cetera, because when they go to see us, they feel stigmatized, they feel blamed, and they feel like it's hopeless. We have to change the narrative and recognize that this is a complex disease and it is not their fault. One of the key things I always start with is looking at the language that we use and really changing that language has been really one of my key things. In the American Medical Association, we changed the language back in 2017 here in Massachusetts. The Massachusetts Medical Society, we changed it. What did we do? We eliminated the word obese. Obese is a label, obesity is a disease. We want to use that people first language, patients with obesity. I've one word that I have really significant issues with is the use of the word morbid as it relates to obesity.

Fatima Cody Stanford:

We don't call it morbid cancer, we don't call it morbid COVID-19, we don't call it morbid heart disease, we don't call it morbid diabetes. Why are we calling it morbid obesity? Indeed, it is severe obesity, but morbid is a stigmatizing term as it relates to it. So the language matters. Let's think about the language we use and we have to give people the respect, the dignity that they deserve when dealing with this disease process that has caused them often a lot of distress over their lifetime. I think it's important for us to just know, it's a relapsing-remitting disease. So you don't just magically treat it and it just goes away, right? It's chronic in nature. So you need to be looking at this over the life course. As I mentioned earlier, I don't care about you lost 100 pounds and then gained 105. I want to see what can we do the sustainable that works for you without any target weight, which goes against what everybody is used to hearing.

My patients come in, they're like, "Hey, Dr. Stanford, what weight do I need to get to?" I don't give them that because I went to the get them to the happiest healthiest weight for them, not anyone else, for them. That's looking at the whole them, their weight in relation to their chronic disease status, looking at their lifestyles, their ability to move and be active. All of these things are extremely important. The reason why we have this weight gain and rebound is because we have something called metabolic adaptation. We saw this on shows like The Biggest Loser, where 96% of those individuals gained weight to their baseline and/or even superseded that.

Our colleagues at the NIH (National Institutes of Health) ran those studies and it was really some of the best studies I've seen that really show how the body's propensity to gain weight is due to those hormones that are pulling you back as ghrelin goes up. GLP-1, which is glucagon-like peptide 1 goes down. This is extremely important. Then we have to think about the cultural appropriateness of our interventions. It is not a one size fits all approach, and I think this is extremely important. I think people also need to be aware that there are a range of therapies that could be utilized for the treatment of obesity. All of our efforts to this point have focused on lifestyle modification, behavioral interventions, which unfortunately fail about 90% of the time. So we need to be entertaining the use of pharmacotherapy, surgical interventions, devices that do have a higher propensity to changing that brain-gut regulation of weight and weight status.

Monica Peek:

I think it's really important to know. I did not know the stats about 96% from that show. That's really incredible. We know we've had some new pharmaceutical agents that have been added to our toolkit over the past two years. Can you talk about some of these recently?

Fatima Cody Stanford:

Yeah. We have a range of therapies, particularly for medications. I'm actually going to go starting from far away and then we're going to come to current times. So we've had medications approved for the treatment of obesity here in the US since 1959. There was a drug by the name of phentermine that was approved at that time. phentermine gets a bad name because it was part of something called fen-phen if you guys remember that from the late '90s, which was a combination of phentermine and fenfluramine. Fenfluramine was F-E-N-F-L-U-R-A-M-I-N-E. That was withdrawn from the market because it caused heart valve issues. Unfortunately, phentermine gets a bad name because it played with a bad kid on the playground. If you hang out with the bad kids, you must be bad. So, phentermine has gotten that bad name, but it's a useful tool for the treatment of obesity.

Fatima Cody Stanford:

We have orlistat, which is available over the counter at your local drugstore under the trade name of Alli, but also can be prescribed by your doctors considered a pancreatic lipase inhibitor. It basically blocks fat. It's not one that we use as much because it implies that everyone that has obesity just eats a lot of fat, which we know not to be true. Also, things that got approved really 2012 and beyond were finally approved by the FDA for chronic use for the chronic disease that is obesity. So a combination of phentermine and topiramate was approved. Naltrexone and bupropion was approved. Then we first began to see these new class of drugs really get approved for obesity. Keeping in mind they were first approved for diabetes and these were what were called GLP-1 agonists.

So the first one to come on the scene in terms of obesity was liraglutide, and liraglutide is FDA approved for the use in individuals aged 12 and up as a daily injection to reduce weight status. But then we started to get in some of our big guns, and before I get into that, there's a device that acts like a pill, which is called Plenity. You take it before lunch and before dinner, and you take it about 20 minutes before with a lot of water. It blows up and produces this jelly. I call it jelly in your belly. So when you go to eat, you're like, "Wait a minute, there's stuff already there." That's how that works. Then we got into some of these big, big guns. These were the GLP-1 agonists that could be used on a weekly basis. One is semaglutide. Semaglutide on average leads to about 15% total body weight loss.

Then one that has not yet been approved for obesity but will likely be soon as being fast-tracked through the FDA called tirzepatide. It's a dual agonist, a GLP-1 receptor along with the GIP, GIP stands for glucose insulinotropic polypeptide. Say that three times fast. That has been shown in the *New England Journal* studies to lead to about 22.5% total body weight loss. Then finally, there was a drug that was found to be really great for rare forms of obesity, POMC mutations, PSCK1, and that's setmelanotide. So we have a variety of therapies. I must note, however, only 1% of individuals in the US right now actually are on therapies with pharmacotherapy for the treatment of obesity. We would not do that with any other chronic disease, but that's what we're doing for obesity. There are multiple reasons why that is the way it is.

Monica Peek:

Yes. Many of them financial and barriers right now. Can you talk a bit about surgery and is this something you recommend to patients? If so, when, how, what are the circumstances?

Fatima Cody Stanford:

Yeah. First of all, I think about using the right tool for the size of the problem. What do I mean by that? Surgery on average produces the greatest total body weight loss. We consider you to be successful with surgical intervention if you lose about 25% plus of your total body weight. This is used in those that have severe obesity or have significant obesity-related diseases like diabetes because we know the resolution of diabetes within the first five days post-metabolic and bariatric surgery in the form of a sleeve gastrectomy where we take away a portion of the stomach and Roux-en-Y gastric bypass where we do reroute a few things and we actually bypass a part of the stomach in the beginning portion of the small intestine can lead to significant weight changes in sustainability of remission of type two diabetes.

Fatima Cody Stanford:

So when I think about this and using the right tool for the size of the problem, I'm going to use a snow analogy. Guys, I hope you're ready. I always tell people like, "What would you use?" I live in Boston, Dr. Peek lives in Chicago, and we have Nijya in Ohio. So we are used to snow. And for those of you who aren't used to snow, don't worry, I'll give you an analogy if this makes sense for you. But if we get a foot or two feet of snow, I ask my patients what would be the appropriate tool to use to move the snow out of the way? Almost everyone will say to me, "You need a plow," which I agree with. So I ask them, why wouldn't they go and use a teaspoon to remove the snow? They're like, "Dr. Stanford, that's ridiculous." "Okay, reasonable. Why don't we get a punch ladle, right? It's a little bit bigger than a teaspoon." "Dr. Stanford, that makes no sense." Okay, then why don't we just get a shovel? Well, how are we going to move all the snow? Do you going to have all these people to shovel? The right tool for the size of the problem here in lies bariatric surgery.

If you have a big problem, big tool, small problem, small tool. Bariatric surgery should be utilized for those that have severe obesity or obesity-related disease starting at the pediatric population. Indeed, I send my patients as young as 13 to surgery. People are like, "Oh, my God, who would send a kid to surgery?" Hold your horses, people, because what I do know is I've published a paper where I've looked at side-to-side comparisons of kids that go to surgery versus adults. On an average, which group do you think does the best? It's our kids because by the time-

Fatima Cody Stanford:

Exactly. We are intervening very, very early. So the remission of diabetes, the remission of high cholesterol almost sustains itself indefinitely in those kids versus the adults because we got it right when it was starting. Indeed, I have seen kids that had surgery 13, 14 now in their 30s, and I'm taking care of them. What I see is a wonderful metabolic profile, one that even is superior to those that have never struggled with obesity, with lower cholesterol levels, lower fat like CLT, which of course, are our liver function tests. All of these things being significantly ideal. Using the right tool for the size of the problem, and we have to recognize that this reduces cardiovascular risk by over 40% and all-cause mortality by over 30%. So why not use that tool?

Monica Peek:

I love that tool analogy. I'm so thankful that you're able to be bilingual in this way, meaning speaking to physicians, but also speaking just as clearly to patients and using these analogies that they can really understand. I think that is more than half of the challenge in trying to engage our patients. So I can tell that you can really make a huge difference in the lives of your patients in understanding the complexity and making the right choices for them.

Fatima Cody Stanford:

Thank you.

Monica Peek:

Nijya, we know that weight's a stigma, which we've talked a fair bit about, can cause stress, distrust of healthcare providers, and subsequent psychological and physical distress and all of this can exacerbate the burden for patients. What can you tell us about this?

Nijya Noble:

Absolutely. This affects the treatment of obesity. What I see every day, our clients saying they do not feel comfortable, they do not trust their healthcare provider. They will not go back to the follow-up getting severe. They're getting diagnosis and coming to me saying, "Well, I don't believe what they say. I don't believe that I'm diabetic. I don't want to start the medication. I don't want to do the surgery because I don't have that trust."

I'm also seeing more binge eating, less physical activity every day. And a major role plays with that stress, I'm seeing elevated blood pressure, elevated A1Cs, and really it all comes back to, "I do not trust my healthcare provider or I do not have a healthcare provider." Within that, I'm trying to do these things all on my own. We're talking about treatment of obesity, it's going to Google, "What I can find and do on my own because I do not trust healthcare?" That as we know is dangerous. That can lead into all different types of things. Then really what I see is that weight cycle, that big White cycle, and really struggling. We talk about a mental health and eating disorders and having success when we're trying to treat obesity due to that distrust.

Monica Peek:

I think that having a trustful relationship with your primary care physician is really important for so many chronic conditions. This being one of those with HIV, diabetes, obesity, certain things that just have stigma related to them being in a safe space where you're managing that disease is really important. Nijya, it's also really important to take ample time with patients at each visit, but especially the initial one. So how do the so-called six As help improve patient engagement?

Nijya Noble:

With the six As, it really sets that guideline, but also the time and the pace. Sometimes just on a rush and go through. So having that time to ask, really getting permission, building that trust right there in the beginning, allowing patients to become comfortable, really assessing, going over what we can within that time, taking that time also to... Don't forget to advise. Sometimes get caught up in listening. Don't forget to advise. But also agree to something. I really always set a goal at the end with my patients and make sure we agree. We talk about. Is that okay for us to do?

Also, have that time to assist with clients, really making sure we have different options available, just options to be available, whether it be a small chat to assist with things when we're not in the office one-on-one, that helps. But then also making sure we have a follow-up in a set date because sometimes I find that, "Oh, just follow up with me, you never see them again." But really putting these steps into place and that all builds our relationship within that. I think these steps are just a really good guideline to really have that relationship in continuing care when it comes to this chronic disease of obesity.

Monica Peek:

Absolutely. That first visit is always the most important one. Fatima, anything you'd like to add before we sign off?

Fatima Cody Stanford:

Well, I think Nijya did a really great job of thinking through this, but I think because we are dealing with a chronic disease, recognize that what you agreed to today may be different in a month or a year or even five years from now. When people start thinking about still seeing me in 5 years or 10 years, keeping in mind this is a chronic disease. So if we can think about that and continue to set goals that fit the patient where they are when they're there, I think we're going to have significant improvement on our dynamic between patient and the physician, for example, or any other healthcare providers and help them feel like they're part of the solution to help them reach their happiest healthiest weight.

Monica Peek:

Absolutely. Thank you for adding that. Being an internist is always about managing chronic diseases and a lot of times surgeons are like, "How can you do it? They still have that diabetes." I'm like, "Yes." So it's about where we are today in that journey in managing those chronic diseases, knowing that the approach may be changing over time, but the relationship and our goals. Where are we today? Before we sign off, I'd just first like to thank you all so much, such stimulating, interesting, informative information from both of you, Dr. Stanford and Miss Noble. Just a superb discussion. I'm going to propose some smart goals, which means specific, measurable, attainable, relevant, and timely action items that everyone can apply to their own patients. Then you all let me know if I've missed anything. Just to summarize.

Identify health disparities that may impact obesity care for each patient, including unconscious bias, prior healthcare experiences, stigma, and shame, to test or retest yourself for implicit bias using the online tool at Project Implicit. Last is to develop individualized treatment plans for patients with obesity that consider social determinants of health disparities, comorbid disease, age, chronic care management, and social support needs. Again, I want to thank Dr. Fatima Cody Stanford and Miss Nijya Noble for joining me today and remind our audience that you can join me here for additional CMEO podcasts, live webinars, case discussions, and other activities.

You can find out about all the upcoming live events and view previous ones on the D&I hub here at the link. Here are just some of the tools and topics that we have covered so far and we'll be adding new content every month. We really do want to hear from you, our audience, on what you need so we can make an impact on these important issues. Please email us at questions@cmeoutfitters.com with your comments and feedback, and we assure you that we read every email, and we really appreciate your feedback. Please remember that you can claim credit for this activity by using the apply for credit button on your screen. Again, thank you so much for our faculty today and to you, our audience, for participating. By tuning in to this activity, you're helping to chip away at the inequities that are still unfortunately prevalent in healthcare. Take care of yourself so that you can provide the best care possible for our underserved patients who need us so much. Thank you again.