Fatima Cody Stanford, MD, MPH, MPA, on COVID complications from obesity

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In today’s COVID-19 Update, Fatima Cody Stanford, MD, MPH, MPA, an obesity medicine physician scientist and an assistant professor at Harvard Medical School in Boston, discusses the potential long-term impact of pandemic weight gain and how obesity increases the risk of severe illness from COVID.

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Speaker

- Fatima Cody Stanford, MD, MPH, MPA, obesity medicine physician scientist

Transcript

Unger: Hello, this is the American Medical Association’s COVID-19 Update. Today, we'll be discussing COVID complications from obesity, and the potential long-term impact of pandemic weight gain with Dr. Fatima Cody Stanford, an obesity medicine physician scientist and an assistant professor at the Harvard Medical School in Boston. I'm Todd Unger, AMA's chief experience officer in Chicago. Dr. Stanford, thank you so much for joining us today. In our conversation before the interview here, you mentioned you're working over 80 hours a week. I know, with the news coming out from the CDC with a startling statistic about severe COVID complications and obesity, there’s a lot to talk about today. Can you tell us more about that study and what we know about obesity as an underlying factor for severe COVID disease?

Dr. Stanford: Absolutely. First of all, thanks for having me here. It's a delight to be with you. Todd, today. I think that one thing that we have definitely gleaned, if nothing else, in terms of obesity as a
disease from this pandemic, is its significant impact on lives. What we see unfortunately with obesity as a disease is that the risk for in-patient significant illness, like require a ventilator, things of that sort, and then dying, sometimes is just three to four times the likelihood of those that do not have obesity. And this has been startling to those of us that weren't doing the work that I do as an obesity medicine physician, but not unfortunately startling to myself. What we do know about obesity as a disease, it is a chronic inflammation that happens within the system. So this chronic inflammation is there, it smolders. And when it interacts with the acute inflammation associated with the cytokine storm of COVID-19 caused by SARS CoV-2, what we see as this bad interaction.

It's a really bad interaction with chronic inflammation, acute inflammation, acute on chronic inflammation. And so this is why we see really worsened issues in terms of sickness and death associated with obesity. When you look at the CDC and how they responded to this new knowledge of obesity and the role it was playing in COVID, if you go back to last summer, they initially just had severe obesity. And for those that are listening, that would be a body mass index greater than or equal to 40 for a high risk factor. But if you pay close attention, the CDC then added obesity as a whole, so not just those with severe obesity. Those that have mild obesity, moderate obesity and severe obesity were now seen as persons that had major risk factor for potential sickness and death associated with COVID. So you saw them add that to the CDC recommendations and those—

**Unger:** And I think that BMI, at least when you look at the guidelines coming out, I think it surprised people. Because I think for a lot of states, it’s 30.

**Dr. Stanford:** Yeah. So BMI greater than equal to 30 is the cutoff. Now, there's been this debate, and for those of you who've seen me in the news talking to different people, BMI is a great population-wide measure. So there may be individual factors that may shift someone outside of this cutoff of 30. And so I do recognize that. I do want to acknowledge that for those that are listening. But for the population as a whole, when we're looking at millions of individuals, which is what we're doing with COVID, it does give us a sense of who we need to be paying attention to and who we need to be getting the highest level of care, who we need to be getting vaccinated, for example, sooner than later.

**Unger:** You mentioned that, obviously, there's a huge comorbidity factor here. I think the CDC study said it's almost 80% of people who have been hospitalized or needed a ventilator had been or have been overweight or obese. That that's a stunning finding. You mentioned inflammation as being a key part of this. When you look at all the comorbidity factors, obesity, is it at the top end of this?

**Dr. Stanford:** Yeah. So actually, depending upon what study you look at, Todd, persons with obesity fall in number one or number two for risk factors. It just depends upon who's doing the analysis, which cohort of individuals you're looking at. So one and two, either one or two in terms of the risk factors that we paid closest attention to, I think that's pretty high. I think we can all agree on that. And I think why this is extremely important is we look at the prevalence of obesity based upon 2018 numbers, which is the latest that we see from the CDC, we know that 42.4% of U.S. adults have the disease of
obesity. That's almost half. Now I know that we're going to get into this, but people have seen an increase in weight status during the COVID-19 pandemic. So that 42.4% may actually be significantly closer to 50. We don't know that. It's usually about a two-year delay on analyzing the current data to see what the prevalence of obesity is within the population, whether it's the adult population or the pediatric population.

In addition, with the kids, it's important to note that we've seen, "Oh, we'll COVID's not so bad in children." The children in where we're seeing bad outcomes with COVID are those that have obesity often. Those are the ones requiring not only ventilators, they're going on machines called ECMO machines and things of that sort. So this is an issue across the age spectrum for U.S. adults and children.

**Unger:** Wow. That's pretty stunning. This is obviously not a new problem. You mentioned 2018. I think, you've probably looked at trends, it's been increasing for a long time. How is this changing how we're thinking about obesity as an issue right now, given the interactions with COVID?

**Dr. Stanford:** Great question. First of all, and we'll plug the AMA. So AMA actually first recognized obesity as a disease back in 2013 when the House of Delegates actually acknowledged it. And it was the first time that a major organization, AMA being the largest of all of the organized medical groups, to say, "Hey, obesity is a disease." And so we started to see some changes back in 2013 where people, doctors alike, began to recognize obesity for the disease it was instead of just a lifestyle choice. But I would say that that attention to its likelihood of being a disease, which it is, and its major impact on health and health outcomes has really been heightened during the COVID-19 pandemic.

People began to hear about obesity. We saw vaccine qualifications rise, such that obesity rose to the top of the list of potential comorbidities that would increase your likelihood of being able to get your vaccine sooner. This has been a major news story. And so I think that people, there's an alarm bell going off, "Wait a minute, this obesity, it's a thing. And it actually can affect my sickness likelihood and the likelihood that I die." And those two things are extremely, I guess, humbling when you're starting to recognize that, especially if you have the disease of obesity and may have discounted its impact on you as an individual before the pandemic.

**Unger:** Dr. Stanford, are you seeing an increased sense of urgency from your own patients? And how is this affecting your own practice?

**Dr. Stanford:** So definitively, I'm seeing an increased sense of urgency. I've been seeing, for example, patients here in Boston at our weight center for almost a decade. And there are some patients that have been in my care for that period of time that maybe I thought needed metabolic and bariatric surgery because they have severe obesity that has been resistant to therapy. Maybe certain patients that needed medication that were resistant to the use of medication that, all of a sudden, it really was associated with COVID-19, that are now saying, "Hey, Dr. Stanford, I want to go to
surgery." And I'm like, "Well, that's interesting. I've been trying to get you to surgery for five years. What is the..." And they say, "I'm seeing my family and friends die and I don't want to be that person. I know I should have done it back when you recommended it in 2015 or 2013 even, but here I am. I'm ready."

But the problem now, or has been during the pandemic is that they have shut off, often, and many different times, elective surgeries. You and I could maybe agree that metabolic and bariatric surgery would be lifesaving in this situation, actually is not an elective surgery. It's not to necessarily just look better. Maybe people think they look better. That's not the goal of the surgery. It's an improve one's cardio-metabolic health. And what we have seen actually, Todd, there was a study that came out just about three months ago that showed that patients that had undergone metabolic and bariatric surgery that had obesity had a higher likelihood of not having any major risk factors associated with COVID, and the risk for dying was significantly less even if they still had obesity. So changing that inflammation, which we see after surgery, regardless of whether or not you still have obesity, which is often common, was really demonstrated quite nicely in that paper that came out of the Cleveland Clinic.

Unger: Yeah. Well, it definitely does move the sense of urgency out of hypothetical and long-term and into, this is real short term threat that needs to be rectified. Are you also seeing ... We talk a lot about different aspects of the pandemic as being just another indicator of health disparities. Are you seeing that play out again in your view and in your field?

Dr. Stanford: Absolutely. If we look at health disparities, particularly the disproportionate impact of obesity on communities of color, we know, for example, Black women, the group that I represent, have, on average, almost 60% likelihood of having this disease of obesity. We've seen that intensify. We've seen more deaths from this population during the pandemic as we look at this disproportionate impact on racial and ethnic minorities, which is, by far, correlated with the higher rates of obesity within these communities. So yes, I continue to see it play out. Also issues with access to health care. Here in Massachusetts, we have MassHealth, and so people from all different walks of life are able to get in to see me. But that is not commonplace throughout the country where access to high-level specialists that are treating obesity, for example, can actually happen.

And so we're seeing this worsen, this issue of obesity worsen as people are socially distancing. They're not as active. They're making sure that they avoid individuals, in order to follow the public health guidelines. But while they’re following the public health guidelines, hopefully, to prevent COVID-19 infection, disease, sickness and death, they are often neglecting other pieces of themselves, that piece of themselves that needs to look at diet quality or physical activity and stress, which we all can agree has intensified during the pandemic regardless of your race, your socioeconomic status. There's been 100% impact of COVID on our lives.
Unger: Yes. This worsening that you're talking about, people have talked about quarantine 15, the COVID-19, I saw, in the news, a study from the American Psychological Association suggesting that may undercount how much weight people are gaining. What is going on out there that you're seeing? And is this playing out with your patients as well?

Dr. Stanford: Yeah, so it's interesting. So I've found that my patients that have already been within my care to treat their chronic disease of obesity have actually lost weight during the pandemic, and that's both my pediatric and patients almost universally. 95%, if I have to guesstimate. I haven't done the study to look at my patients, but 95% actually have lost during the pandemic. They've been conducting telehealth visits with me throughout the pandemic, so have been able to check in every two to three months to check on their status, which has been great. Now, for those that are coming in to me as new patients, and right now our waitlist here at Mass General exceeds 700 patients waiting to be seen, so that's a lot of people.

Those people that are coming in as brand new patients often cite that one of the reasons that they have sought care is because of not only the weight that they carried pre-pandemic, but that additional weight that they have gotten during the pandemic. And so yeah, so you're seeing those new patients come in. They're saying, "COVID has really affected my weight status." You go and look at their graph. I chart them out over the last 10 years. And you do see this spike for many of them. So I think that's what we're seeing around the country, especially for people that have not had chronic care and treatment for their obesity, or excess weight if they don't have obesity.

Unger: And do you see this issue playing out past the pandemic, in terms of just highlighting just how important it is to get that under control, long-term for our country?

Dr. Stanford: Yes. And I was hoping, with these different stimulus bills and things of that sort, that we could have seen a little bit more action on things like obesity. For example, TROA, which is the Treat and Reduce Obesity Act, we've been trying to get through Congress for the last six years. We have strong bipartisan support. Really, TROA, which is the Treat and Reduce Obesity Act is set to cover two things. Number one, behavioral treatment for obesity. So right now, if you have obesity but don't have diabetes, you still are paying quite a bit out of pocket to meet with a dietician. Now, if you get diabetes, all of a sudden, that visit is covered. Hmm. That seems a little bit backwards. Why not treat the patient before they develop diabetes, which is obviously an even more severe risk factor sometimes than obesity itself. Number two, coverage for medications for obesity. Only 2% of patients, Todd, in this country that meet criteria for the utilization of medications for the treatment of obesity actually get access to it. 2%. So we have 98%, 2%. We can say that we're probably under-prescribing these medications.

But a lot of it has to do with coverage. A medication is only good as the one that I can get to my patient. If it's such an exorbitant cost out of pocket for that patient, they're not going to be able to take that medication for their chronic disease of obesity. So the two tenants that we're hoping to get
covered are coverage for a dietician and coverage for medications. Really simple. We do that for every other disease process from asthma to diabetes to heart disease. Why can't we do that for obesity, which affects a much larger percentage of the population? And so it would have been nice to see something like that get through, this must need pass legislation. As we give economic relief, why not give health relief for patients that need it, also looking at just the high predilection for obesity in our country?

**Unger:** That makes so much sense, given what we're seeing as the the potential cost of not treating it earlier. Well, last question for you, and related. You've been really vocal about anti-obesity bias in medicine. What does the medical community have to learn in order to treat patients more effectively who are struggling with weight issues, post-pandemic?

**Dr. Stanford:** So, first of all, it's all about language, language, language, language. Let's start there. So the that we use has huge implications on how people engage with us. So the AMA in 2017 passed a wonderful resolution where we kind of canceled the use of certain words. Number one, obese. Obese is a label. It's often highly stigmatizing. Obesity is a disease. So when I talk about patients with obesity, much like the resolution that we passed in 2017, you say a patient that has obesity, has mild, moderate or severe obesity. Let's go to that severe category. Severe obesity is a category. But this term morbid obesity, highly stigmatizing, "Oh, they are a morbidly obese person." Both of those words just made my heart have palpitations because I could sense what my patients must feel when that's stated. So we've canceled the use of morbid as it relates to obesity. We don't call it morbid COVID, but we've lost over half a million people. We don't call it morbid cancer or morbid anything else. So the language we use with patients can be highly stigmatizing. We need to be thoughtful about that.

And we need to recognize that for patients with obesity, that we need to remove the blame and often take ownership of what we can do to help the patient get better. This is not to say that, "Hey, I don't want you eating healthy, or I don't want you exercising, or I don't want you to minimize your stress or maximize your sleep." It's not saying those things. Those things we'll work on. But often, especially for patients that have had a long-term history of obesity or have severe obesity, those things alone will be ineffective for getting weight status to improve. If that's the case, then I need to be doing what I can as a doctor to help support. I always tell patients, "I'm the coach, they're the star player." If they don't show up to the game, I can't coach it. I can't coach a game where there's not a player, especially the star player. That's the one that's going to help me win the game." For me, it's not winning the game for me, it's winning for them. So I want to help them be their best self.

**Unger:** Dr. Stanford, do you think that physicians are getting the proper training, in medical school and beyond, to deal with obesity?

**Dr. Stanford:** The answer is a resounding no. Actually, I published a study in the "International Journal of Obesity" just at the beginning of 2020, where I had done a deep dive in looking at training surrounding obesity as a disease everywhere in the world, in medical students, resident physicians,
fellow physicians, in the entire world. And you know how many times you can say, "Oh, well, Sweden did a great job or they did a really great job in South Korea," for example? There is no country, including us, obviously, that has done a great job of educating how to treat this disease of obesity. And it's dismal. I can tell you that we need to do better, not only here in the U.S., but everywhere in the world, because obesity is everywhere. And we're not doing a good enough job.

I think that we need to make sure that there's an elevation in obesity in the curriculum, make sure that it's actually being taught and not just something that's, potentially you could learn about it, because it's affecting large percentages of the population, about 20% of kids, almost 45% of adults. Those are large numbers. Why are we not learning how to treat this disease? And that is part of why I do so much to give lectures and give interviews, because at least I'm hoping that I'm doing something in terms of teaching those that can go on and have an impact on patients.

Unger: Well, that is an excellent question. And I just can't thank you enough for all the work you're doing at this critical time. That's it for today's COVID-19 Update. Dr. Stanford, thank you again for being here and sharing your perspectives. We'll be back soon with another segment. In the meantime, for more resources on COVID, visit ama-assn.org/COVID-19. Thanks for joining us. Please take care.

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