Obesity in communities of color: A closer look at addressing existing disparities

Featured topic and speakers
Even before the COVID-19 pandemic, obesity has affected communities of color disproportionately, due to systemic racism and other health inequities. In this episode of AMA Moving Medicine, experts discuss and debunk obesity health myths among patients of color.

Speakers

- **Tammy Boyd, JD**, chief policy officer and counsel, Black Women’s Health Imperative
- **Fatima Cody Stanford, MD, MPH, MPA**, obesity medicine physician and scientist director of the Nutrition Obesity Research Center at Harvard (NORCH) Massachusetts General Hospital/Harvard Medical School
- **Nikki Massie, MA**, board member, Obesity Action Coalition
- **Joe Nadglowski**, president and chief executive, Obesity Action Coalition

Moderator

- **Shyrea Thompson**, founder and principal, The IRIS Collaborative, LLC

Host

- **Todd Unger**, chief experience officer, AMA

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Transcript

**Unger**: Exacerbated by the pandemic, obesity affects communities of color disproportionately, due to systemic racism and other health inequities.

**Dr. Stanford**: These inflammatory markers actually increase stress, actually increase storage of fat. If we don't address racism which is commonplace and we see play out every day as our young Black girls and boys are being killed just for living and being, then we're not going to be able to tackle obesity in the way we need to do to decrease the disparities that we see particularly amongst the individuals that are from the Black community. Now, we know that there's also disproportionate so that we see issues within communities of color as a whole.

**Unger**: That’s Dr. Fatima Cody Stanford, director of the Nutrition Obesity Research Center at Harvard Massachusetts General Hospital.
On this episode of Moving Medicine, Shyrea Thompson, principal and founder of The IRIS Collaborative is joined by Tammy Boyd, chief policy officer and counsel at the Black Women's Health Imperative; Joe Nadglowski, president and CEO of the Obesity Action Coalition; and Nikki Massie, board member of the Obesity Action Coalition—for a discussion on obesity in communities of color. I’m your host, Todd Unger, chief experience officer at the American Medical Association. Here’s Shyrea Thompson.

**Thompson:** And I'm excited to be joined by this esteemed group of panelists to actually unpack more about how obesity in communities of color, and a closer look in addressing those existing disparities, can actually advance equity. We are looking forward to getting started and I'm going to just quickly tell you who we're joined by today and then we're going to actually allow each of them to tell us a bit more about how they're working to end disparities in communities of color.

I'm Shyrea Thompson, I'm the principal and founder of The IRIS Collaborative. We're also today joined by Tammy Boyd, who is the chief policy officer and counsel at the Black Women's Health Imperative. We also have Dr. Fatima Cody Stanford, who is the director of the Nutrition Obesity Research Center at Harvard Massachusetts General Hospital, Harvard Medical School and she's also a fellow 40 Under 40.

And we also have Joe Nadglowski, who is the president and CEO of the Obesity Action Coalition. And we will be joined ... oh, Nikki has been able to join us as well, who is going to bring that patient perspective. And she is the chair of the Obesity Action Coalition, inclusivity and diversity committee. And she and Joe work together doing the incredible work, bringing the patient voice to this work. We're going to go ahead and get started and hear from each of you. So Dr. Fatima, if you'd like to start, we'd love to hear a little bit more about how you're bringing the provider voice, the physician voice, into the work that you do and the role you play in addressing obesity disparities. Dr. Fatima?

**Dr. Stanford:** Absolutely. Well, thanks so much for having me this morning. As was stated I'm an obesity medicine physician scientist here at Mass General Hospital at Harvard Medical School, and I'm really keen and what brought me to this work actually in obesity was the disproportionate impact that we see on communities of color but particularly amongst Black women. What we do know if we're looking at U.S. adults is that 42.4% of U.S. adults have this disease of obesity based upon 2018 data which is the most current data we have out of the CDC. But we have this disproportionate impact of obesity, particularly in Black women, and I have been really committed to figuring out why this is.

People presume it's just because we have things that we choose to do, that it's our fault. Like, oh, maybe we don't want to get our hair wet and we want to do our hair to look great, which is something that for example, Regina Benjamin brought up in her role as surgeon general, if you recall. I mean, that is indeed definitely one thing but is that really the end-all be-all for why women, maybe that Black women are less active? I would say not necessarily.
And we have to think about racism and its implications for excess weight within the communities of color. For example, the Black Women's Health Study—which is the largest cohort study that's ever been done in Black women to date—has shown that both daily and lifetime racism lead to a poor health response but specifically higher levels of obesity. And what we think is associated with that racism is increased stress which leads to increased inflammation and deposition of what we call adipose. Adipose tissue is fat tissue but particularly in the area we don't want it, which is in our midsection, which of course leads to other chronic diseases like diabetes, fatty liver disease, for example.

I have been working to really delve into this higher prevalence of obesity within Black women. What we do know is about 60% of Black women have obesity, about 20% have overweight, which means that we have 80% of Black women that have overweight and obesity. And these numbers are pronounced and I think it's the issue that we are not dealing with. We've seen this rise to the level of significant importance as we've seen this COVID obesity connection. We have this chronic inflammatory condition of the obesity interacting negatively with this acute inflammatory process of COVID-19. And that is what's contributing to this greater risk of both sickness, need for ventilator use and, unfortunately, dying from COVID-19. And the reality is that this is indeed hitting our families.

When I think about my family itself, my parents have lost 16 of their friends to COVID-19. Sixteen, I cannot put those fingers up to show you. My best friend lost her father to COVID. One of my mentees, one of the top 40 Under 40 that's ... today lost both parents to COVID-19 three weeks apart, one on Easter Sunday last year and then one three Sundays later. This has affected us and it's affecting us regardless of our social-economic status. We know that obesity is playing a role and we really need to hone in.

My goal is to offer the best possible care as it relates to treatment for those that have this disease of obesity, whether we're looking at metabolic and bariatric surgery for those that have moderate to severe obesity, the use of pharmacotherapy agents for those that would require lesser care and then just really care along the continuum. Looking at lifestyle modification, behavioral interventions to compliment this need to treat this chronic disease of obesity.

And so I'll stop there so I can lend the mic to my fellow, I guess, panelists here, but this is really the work that I'm doing along with the research efforts I'm doing to really begin to understand why we see this higher prevalence of obesity and how we can tackle it and address it within the Black community, particularly.

**Thompson:** Exactly. You hit on a number of points but I'm going to head over to Tammy, and she's going to talk a little bit more about the role she plays and bring that policy voice to it. Tammy, can you share a little bit more about your role?

**Boyd:** Yes, absolutely. I'm Tammy Boyd. As mentioned, I am the chief policy officer and counsel for
the Black Women's Health Imperative. And Black Women's Health Imperative is a national nonprofit organization dedicated to advancing health equity and social justice for Black women, really across the lifespan through policy, advocacy, education, research and leadership development. And the organization, BWHI, we really identified the most pressing health issues that affect the nation's 22 million Black women and girls.

And so for us what we bring to the conversation is that, obviously, we are very concerned about obesity and how it impacts, and as we've heard from Dr. Stanford, how disproportionate impacts on communities of color and for us specifically, Black women. So we are concerned with just the overall continuum of care for obesity from the eating healthy food and physical movement, which we have a Change Your Lifestyle program, behavior modification, obesity modification, surgical procedures and just maintaining mental health. We are very interested in what we bring to the work, is the overall continuum of care for obesity.

Thompson: Thank you, Tammy. Black Women's Health Imperative and your work has certainly been a leader in this space and presented a number of conversations of a positive patient-focus lens. I really appreciate that. And with that in mind, we're going to head to the patient advocacy part of today's panelists and hear from Joe, and then we'll hear from Nikki. Joe, if you can tell us a little bit more about your role and also if you'd like to highlight how you and Nikki work together to bring that patient lens.

Nadglowski: Sure. Thanks again for having me today, I really appreciate the opportunity to be here. And so, I run the Obesity Action Coalition which is the patient advocacy organization in the obesity space. We're actually an organization of people who live with obesity, who are working together to support each other. And we spend much of our time and I won't belabor this because I'll let Nikki have a chance to talk about it as well, we spend much of our time trying to reduce the stigma around obesity, meaning let's make it okay to talk about obesity, let's make an okay to ask for help to address obesity.

And then, of course, because we're asking people to make it okay for them to ask for help, we spend a lot of time on policy efforts to make sure that if you want help you have access to it. And Dr. Stanford did a great job talking about what the continuum of care would be in her opening remarks though I spend much of my time doing that and do it through a broader coalition. It's just not always seen as the patient, so I also co-chair a group called the Obesity Care Advocacy Network, which really is focusing on how do we change the perception and approaches to address obesity.

And the cool thing about OCAN is it's such a broad coalition. In fact, Tammy sits on that, Dr. Stanford sits on that and others that I always see on the other groups involved sit in that as well, to be able to take this broader approach to addressing obesity. Because it won't just be the patient advocates, it's going to be a combination of all of us that have to work together. And again, just not obesity groups, it has to be those that live in the associated conditions, who are working on specialty care groups like...
the Black Women’s Health Imperative, others that participate to be able to change the world. Thanks again for having me today.

**Thompson:** Thank you, Joe. Nikki, we’re going to hear from you. And I just am so grateful that you’re able to join us today because you’ve got such an excellent perspective and you share your story with such grace. Can you tell us a little bit more about your role?

**Massie:** I serve on the National Board of the Obesity Action Coalition, and then I chair the inclusivity and diversity task force. And I started out with the OAC as just a person who herself is living with obesity and wanting to connect with others. When I found out about the mission of the OAC, I was very happy because, as Joe said, there’s a lot of emphasis on making it okay to talk about obesity. I know that in my life it is a family affair. My mom was affected by obesity, my dad still is affected by obesity, my children, cousins, aunts, uncles. And so building sort of this culture of talking about it not as a negative trait of a person and as a health problem was really, really important to me to build that culture.

But then when we started talking about inclusivity and diversity, just sort of making sure that we, number one, are being inclusive in our imagery. One of the things I love about how the OAC approaches imagery is portraying the whole person. You often see very, very stigmatizing photos of people with obesity, maybe just their midsection or they’re sitting in front of a triple cheeseburger. And they really have been working to get people with obesity that go biking, they take walks, they cook for their families, they interact and all of these different things, but then also making sure that all types of people see themselves in that imagery.

And then also making sure that we’re being honest about the fact that obesity does not affect every population the same way and that different interventions may or may not work with different populations and keeping in those conversations so that we can have a real conversation about where disparity, bias, inequity exists and work to address those things.

**Thompson:** Well, thank you. You brought out a number of points that actually bring me back to Dr. Fatima. And along the lines of what you do, obviously as the physician and the specialist here, I wanted to talk to you a bit more. You actually recently shared how obesity is a manifestation of systemic racism. Can you tell us more about what led you to share that and the work that you’re doing to really talk about the intersection of racism and obesity?
Dr. Stanford: Well, I think ... first of all, thanks for that question because I love to talk about this topic. But I think that when we look at what's happened over the last year plus with this COVID-19 pandemic is that we've seen a collision really of three pandemics. And the three pandemics were COVID-19, followed by obesity and I would say obesity maybe was a precursor, and then racism which has been here as the early precursor. And the collision of these three have been magnified in the current status of what we're seeing. And so it's unfortunate, but I began to really see how the interplay of those three pandemics has really led to worsened outcomes.

I recently published Obese Piece, an entire piece on how we can begin to address racism and its implications for obesity within the Black community. We know that when we experience racism that we feel significant stress. Sometimes you just walk it off, sometimes you might actually go and do a march as we've seen with the murders of George Floyd, Ahmaud Arbery, Breonna Taylor, to just name the three that were most prominent during this COVID-19. But let's look at what just happened last week or this week that we're seeing in North Carolina, this constant stress leads to inflammation in the body. We see elevated levels of IO1, IO16, alpha MCP-1, tumor necrosis factor alpha, you don't have to remember all those things, but these inflammatory markers actually increase stress, actually increase storage of fat.

If we don't address racism which is commonplace and we see play out every day as our young Black girls and boys are being killed just for living and being, then we're not going to be able to tackle obesity in the way we need to do to decrease the disparities that we see particularly amongst the individuals that are from the Black community. Now, we know that there's also disproportionate so that we see issues within communities of color as a whole, within the Hispanic community or the Latinx community with high rates of obesity. Within the Native American community, we're also seeing it.

And so we do have this interplay of potential disenfranchised groups experiencing stressors that lead to an increase in obesity. We have to recognize that these things do not operate in a silo and there's integration and we need to have a multifactorial multi-pronged approach to address these issues as they exist together in the same mill. So hopefully that helps understand why I've begun to address this and I told you what brought me to this work was looking at the disparities that existed, back when I was brought to this work many years ago.

Thompson: Now, that was excellent. And you spoke to many of those social determinants that many of us are aware of. And I love, later on, we're going to get more into those best practices and those frameworks because we're not here to admire the problem, we really want to make sure that people can leave today knowing how to connect with each of you to actually advance the work in their own communities, or look for tools to actually overcome some of the barriers that they're facing in their work as well.

I'm going to head over to Tammy and actually talk a little bit more about how policy can play a role in
addressing obesity disparities. And then if you can share a little bit more on the current state of coverage for anti-obesity medications and how can we get better coverage. And I know that you're going to be able to give us some examples, Tammy, but if you can speak to the policy piece and let us know what's the current status with Medicare and Medicaid.

Boyd: Yes. And to the legislation, or the policy, that's on the Hill that we're currently supporting that addresses obesity, it's called TROA. It's the Treat and Reduce Obesity Act of 2021. It was recently introduced in March in the Senate and in the House by Senators Tom Carper and Bill Cassidy and Congressman Ron Kind and Tom Reed and Raul Ruiz. And the bill aims to effectively treat and reduce obesity in older Americans by enhancing Medicare beneficiaries' access to health care providers that are best suited to provide intensive behavioral therapy but then also for us, most importantly, by providing access, allowing Medicare Part D to cover FDA-approved obesity drugs.

And really for us, it's really to help people of color living with obesity. We need to ensure that they have access to the full range of comprehensive obesity care, including lifestyle counseling and other medical interventions included, including FDA medications and surgery. So, we are really working to help elevate obesity as a serious chronic disease affecting communities of color, particularly for Black women. And I know Joe may have more to add here as well, but yes, on Capitol Hill there's an effort around the TROA Act of 2021.

Thompson: Thank you, that's excellent. Joe, would you like to weigh in? I know that you're partnering in advocacy, you can't do it alone.

Nadglowski: Yeah, no, I appreciate that and I think Tammy did a great job talking about the treatment of obesity. I think our goal of course is to make it so that if you see someone like Dr. Stanford and they want to help you with your obesity that you have access to the treatment options that are out there. And there are evidence-based treatment options out there and so it is very important that people have access. And you might ask us, "Well, Joe, why Medicare?" I mean, that is directly affecting us but I think everyone here just to be very clear is what Medicare does, everyone else follows. So if Medicare does it then employers will start doing it, general insurance will do it, Medicaid and other assistance programs will do it as well. And so that's why we're spending so much time on that.

And the reality is many of us do have some coverage. You might likely be able to be counseled by your physician and or maybe another health care specialist. You probably have access to bariatric surgery for those that are most at need but it is that middle ground around anti-obesity medications and other therapies where it seems as if people are lacking treatment options and so we spend a lot of time trying to get folks in the middle, to get that coverage for folks and moving forward.

And we see progress. I will just want to be very, very clear that we have seen progress. In fact, this week alone I worked on a Medicaid bill in Minnesota that's looking around adding anti-obesity medications. Not done yet but it's in progress and so I think we're starting to see more and more of
this coverage comes across the country. I do appeal to the audience numbers, if you’re going to ask your provider and they say, "Hey, that's not covered," challenge them a little bit on it. It may not be covered but our coverage is getting better every day.

**Thompson:** Well, Joe, I was going to actually ask you what is the call to action and it sounds like you've given one. But I want to pause, is there anything else that you would say is the charge here? Not just for people listening but if you’re a policymaker, if you’re a physician, a community leader, churches, faith-based organizations, what role can everyone play in advancing this and what would you say is that call to action?

**Nadglowski:** Right. Yeah. That individual call to action to me is it's always my individual call to action is actually not to be afraid to ask for help for your obesity. I'm going to say that I've said it several times and I'll say it again. But from a policy or systemic wise, really we have to focus on making sure people have access to the continuum of care. And keep in mind that is evidence-based prevention, how do we prevent obesity? How do we make sure that these programs are actually put in your community and actually designed appropriately to meet the needs of the community that's in place?

We have to address all the social determinants of health. I can actually talk all I want about let's get insurance to cover these services but if you don't have insurance in the first place, we haven't addressed that issue and so we have to address those issues as well. And I really do think that we have to convince Congress to start by passing the Treat and Reduce Obesity Act, it's the start. We will then have comprehensive care under Medicare and then I think we can push that down moving forward.

When it comes to employers, faith-based groups, et cetera, I really would challenge you to take a look at your benefits, take a look at what services you're offering. Many of you likely say, "Hey, we have a wellness program for employees or our members," kind of thing. But is wellness enough? Remember we heard those statistics from Dr. Stanford earlier, 80% of Black women are affected by overweight or obesity, we’re beyond just prevention in that group. We may have to look at other interventions as well. So are you doing a good enough job if you're saying that you want to do something about obesity? Just giving everyone a key to the corporate gym likely isn't enough, we have to have these more comprehensive programs in place.

And then finally, one last point here on faith-based organizations. I think you have such an important role in addressing health issues. And I think COVID has set that back a little bit because we're all going to church virtual and doing those things now, but also COVID proved that we have to focus more on chronic disease and, specifically, on obesity because of the consequences with it. And so as you're getting back together, as you're thinking of ways to be more creative and to support the health of your members, it's time to start thinking about obesity specifically and think about how we can do this again in an evidence-based way.

Go to the folks like Dr. Stanford and others who are experts in this and actually find out what, this is
not what you think might work, this is what the evidence says will work. And I think that's part of our challenge. Sometimes is a lot of people think they know what will work and the reality is the evidence says it doesn't, so it's actually something different that works. And so just my challenge for the faith-based groups to think about that quite strongly but take an opportunity here especially in light of COVID.

**Thompson:** Well, I see Nikki there reacting to some of that, and we were going to head to the patient perspective next. And Joe, thank you for highlighting some of those pieces. Nikki, I shared that I had a chance to learn a little bit about your patient journey but I'd love for you to share it for those that might just be meeting you for the first time. Can you just share a little bit about your patient journey towards health and wellness and what are the biggest barriers in your opinion or in your expert experience that patients have in accessing information, resources and referrals to proper care. And then finally, why do you think it's important for patients to have access to obesity specialists like Dr. Cody?

**Massie:** Sure. Well, my journey toward better health and addressing my weight started back in 2008 ... well, I would say 2007 is when I really started working toward it. At my highest weight I was about 350 pounds and I had these two small children, I wanted to get healthier. I sought out bariatric surgery. I did get a little bit of the runarround from my insurance company, that's a whole other story. But finally, in the early part of 2008 I was able to have gastric bypass surgery. And that really was a launching pad for ... that's very much the first step to a bunch of changes in my life that have led to where I am now.

As a result of that, of course, I started focusing in a lot more on my weight and my health, but then also I became holistically more aware of different health issues. With gastric bypass, in particular, there's vitamin supplementation that has to happen, there's blood work that has to happen, there's this follow-up that has to happen so you really do have to stay on top of it and pay attention. And here I am 13 years post-op and still having to work with my doctors to make sure that my health is up to par because when you have bariatric surgery, no matter what kind of surgery, but I would say especially with sort of the malabsorptive surgeries like the gastric bypass, your body just simply doesn't work exactly like everybody else. So you have to educate yourself a lot about how your body works.

What leads me into some of the challenges that I see from a patient perspective. One of which being that for the average patient when you think of where health care can live or die, can advance or stop dead in its tracks, it really is in my opinion at the primary care physician level. Most people will go see their doctor if they have some sort of problem. But primary care physicians inherently, and Dr. Stanford can probably speak on this, I don't think that they automatically have any specialized training in obesity even though obesity is such a widespread issue in the medical community.

A lot of them certainly don't have a lot of experience with bariatric patients and malabsorptive bariatric
patients so that's led to a lot of adventures on my part, but then also folks who follow me on social media I hear a lot of those sorts of things because you have to navigate that structure. So if you think about the person who is just coming in for the first time, they know that they need to address their weight, they know that they have health problems and things like that.

And you meet your primary care physician. A lot of how that proceeds is predicated on the philosophy, I guess, of your primary care physician. They can either choose to open a lot of information up to you and say, "Hey, there are these obesity specialists. You can go to a dietician, you can do this, you can do that." Or they could say what my children's pediatrician said to me for years and years and years as I watched them struggle with their weight as children was, "Oh, well, just eat half of your plate and go for a walk every day."

And so it was so frustrating and, thank goodness, they had me as a mother who I knew that there were things beyond that that could be done. But for a lot of people when you go to your primary care physician, there's a power dynamic going on. They are the doctor, they have the medical knowledge, they are telling you, sort of making a value judgment, "You're eating too much, you're not moving enough." They're not addressing the fact that there are all of these other reasons why you may struggle with your weight and they're not telling you what your resources are beyond what their specialization is.

A lot of times people don't know whether they can or how to go directly to a specialist. And then one of my experiences that has marked so many points of my personal journey is the lack of coordination. I eventually got fed up with it all and moved all of my care into the same medical health system so at least all of my records were digitized under the same medical health system. But it can be my bariatric surgeon isn't inherently connected with my primary care physician, isn't inherently connected with my dietician. None of these people are talking to each other so it's my job to go back and forth between these people to manage my own care, and it's a lot.

And when you think about all of the stresses that we've already talked about, especially the Black women face constant stressors from the effects of systemic racism to a lot of times being the head of household in their household. Myself, I'm a single mom so I've been raising two kids by myself, it's a lot to expect all of what life expects. And then I have to be my own medical caseworker in a lot of instances. And I see that as a barrier because honestly, in my opinion, if I could just go to the doctor and say, "Hey, I want to address my weight," and then have that practitioner come back to me and say, "Okay, let's have a real conversation about it, let's talk about what we can do. Let's get you connected to some folks," and lead the journey from that point forward, that I feel like it would make the journey so much easier and would make it more likely for people to follow through if they didn't have to figure out everything themselves.

**Thompson:** You said so much. My background is in breast cancer and when you think about the fact that obesity is a chronic disease and you think about the fact that we've fought so hard in that space
to get patient navigation and to advance community health workers to close many gaps, and to hear what you're outlining. For me, I'm hearing maybe that's the next advocacy piece, how are you working to close those gaps and make sure that you're not walking that path alone, empowered people are certainly empowered patients. But I get it, and especially when you've got that mama bear factor, you're trying to worry about yourself and your household as well. So thank you for really highlighting those real factors that we all face.

I'm going to actually head back to Dr. Fatima and Joe. We wanted to have an opportunity to hear what progress you've made and what best practices or studies or research you can speak to that people that are listening may want to look up. We talked about evidence-based practices, is there anything you'd like to highlight in the past year?

**Dr. Stanford:** Absolutely. I published 39 peer-reviewed papers last year so it was a busy year for me. But there are two that I really want to bring out. I hear Nikki talking about her experience and I think about the physician piece of the puzzle, where are we failing our patients? And we are failing them because we have not been educated about the disease of obesity. Now, not me, I did three years of fellowship in obesity, but let's talk about what people are receiving when they go to medical school, residency and fellowship.

I published at the beginning of 2020 a paper that was published in the International Journal of Obesity, where I looked across the entire world to see what's being taught in medical schools, residencies and fellowships surrounding obesity. And it's really a dismal state—no one is teaching obesity—that's really the answer to the question. And we can't highlight one country as being the exhibit for how we should be. Here in the United States no one is doing a good job despite the worldwide prevalence of obesity as the most prominent chronic disease in the entire world. So that's number one.

Just within the last two weeks, in the Journal of the National Medical Association, I looked at all of the medical board examinations from pediatrics to internal medicine, family medicine, surgery, anesthesiology, to see what is being covered on the topic of obesity on medical board exams ... a dismal state. Of the 24 American board exams, we were able to look at the content outlines for 23 of them and obesity is minimally covered amongst all of them.


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What I can tell you as physicians as we spend a lot of time studying, as we study for the test, we study for what's important, how do we pass the test? We pass the test based upon what they say is important. If obesity is not being covered on all of the board exams it must not be important, we aren't learning it. And so what they tell you to do is turn to your doctor and, unfortunately, you turn to your doctor and your doctor knows less about obesity than you do, unfortunately. It's really the reality. Now, there has been a shift in the last year. We have seen more doctors become certified by the American Board of Obesity Medicine. There are now over 5,000 physicians that are certified in obesity medicine in the country.

If you're trying to figure out where do you go? You just go to the American Board of Obesity Medicine site and you can actually search, free of charge, by zip code for doctors that are certified in your area. That is a major shift, a major improvement. We have a little over 4,000 doctors last year, we've added an additional thousand, so we are making some progress. We're talking in the order of over 100 million adults with obesity.

I just want us to put that in context. 5,000, over 100 million, we still have a significant disconnect in terms of the needs, in terms of those of us that have actually done fellowship training in obesity medicine. Only about 50 people in the country who've completed fellowships in obesity medicine. Fifty, 100 million adults and we have kids, I see children and adults. We still have a lot of work that needs to be done. But we do want your doctors to be a trusted source of information, we just need better education and this needs to be a thrust, a focus point. I'm going to Tammy if we're thinking about policy points, to Joe if we're thinking about policy points.

We need to put the pressures on medical schools, residency programs, fellowship programs, the board examinations to test this material because people are going to come walking through the door and we're going to continue to say to them, "Eat less, exercise more." Which is exactly what Nikki heard. Oh if you just eat half of this. Is this really going to happen? I can tell you, I did my residency training in South Carolina. I'm in Boston now, I'm from Atlanta, I sound like a news reporter where nobody ever can pick up where I'm from.

But when I was in South Carolina seeing young boys that were 15-years-old with body mass index, and just a note to the audience, anything above 40 is considered severe, but just seeing people with body mass index of 65 and my note to them based upon what I was taught, "Oh, well, can you just drink skim milk? And maybe you can do a little bit more exercise." They're carrying 250 pounds in excess and we're thinking a change to skim milk and a little bit more exercise is going to bring down in any substantial way that degree of excess weight? That is a deplorable.

And I really am frustrated with the medical community as a whole. I would lose my medical license if I were to treat diabetes in that same way. Someone came in with uncontrolled diabetes and I tell them, "You know what? If you could just eat a little less sugar and just move a bit more and then come back and see me." They ended up in the hospital with severe diabetes and may die from that. Similarly,
you can die from your obesity. We know it increases morbidity and mortality, but it's perfectly fine for me just to say what Nikki was hearing from her doctors about what she should do for her children, her daughters that were born into this family where obesity was commonplace.

And I do and I would be remiss if I did not say this before I turn it over to you, Joe, is that weight is more heritable than height. And I always want to make sure that we get that across. Weight is more heritable than height, which means that if we have families in which there is obesity a likelihood that your children will have obesity because of that genetic and epigenetic function is on the order of 50 to 85% likelihood. That's a higher contribution to who you are than if your parents are tall, like if your dad was Shaq for example, there's a high likelihood you'll be tall, although his wife was short, maybe not.

But the whole point is, is that we see tall parents and we presume tall children. When we see parents that have obesity, unfortunately, the children and/or the grandchildren, and I'm taking care of some families here at the weight center where I'm taking care of great-grandparents, grandparents, parents and children for generations, and you see that continuum along that line and particularly in communities of color. I mean, that's a lot that's happened in the last year, we could keep going on and on.

Please read those pieces that are published about obesity and systemic racism in the Journal of Internal Medicine, other pieces that really allude to that, like we talked about in terms of the education world. My goal is to change the narrative and I think we can do it, but it's going to take all hands-on deck and we in the medical community need to step it up because we're not, we're failing our patients. We're not doing a good job.

Thompson: Well, thank you for your candor. Joe, was there anything else you want to highlight from the patient advocacy perspective?

Nadglowski: Yeah, just two things that ... and one Dr. Stanford alluded to is around training, so actually a very curious progress as a positive in my mind that I participated in this year and I actually know Dr. Stanford, we've already communicated about you participating in the next year, is actually we participated in a medical training program for chief residents that was actually in internal medicine, teaching them about obesity. And that was a weekend course, that's not enough but it's a start to me that we're actually starting to see more folks interested in that space. And this was put on by a group called the Primary Care Metabolic Group. But it was exciting to see actual residents who were excited about helping people with their obesity and actually the messaging that came through is just such a positive one. Again, your provider can be a partner in addressing your obesity, not a barrier.

Then the other area I just wanted to highlight that's just been interesting, that's changed over the last year, has been actually related to COVID and that is the vaccine allocation. Actually, for the first time that I can remember it was actually an advantage to having obesity and that was, in many states you could actually access the COVID vaccine because it's considered a chronic disease and moving forward. And to me that was actually a little bit of progress. We actually saw state regulators, federal
regulators, for sure recognized obesity as a chronic disease and as a long-term health risk and so I think it was important that that happened.

Now, let's be honest with you. There were some notable exceptions. There were some states that didn't do it so we still have work that needs to be done and actually some regions that didn't prioritize people with chronic disease like obesity. But to me it was a bit of progress when it comes to how people are thinking about obesity.

**Thompson:** Did you want to speak to that, Nikki?

**Massie:** Yeah, I just wanted to say I think it is great that that was recognized in vaccine administration. Where I feel, from a patient perspective, we have a lot of work to do is with the notion on the patient's side that that's somehow cheating or cutting in the line or that they don't deserve to have the vaccine first because of obesity, because we've made it like that. Like I said the value of the person or the type of person that you are because you have obesity, because I as soon as ... I think I heard it from you, Joe, and I started shouting it from the rooftops, I'm like, look, if your state is in a stage where it says if you have a medical condition you can get the vaccine. You can get the vaccine on this basis, call somebody. And that's a lot of what I got back from people is, "Oh, I don't want to use that. I have really taken care of myself, why should I be ahead of the line of so-and-so and such-and-such." And so, I did see that dynamic a lot on social media.

**Thompson:** Well, actually that takes us to our next question, and I was going to ask you and Tammy, but before I ask you the question around stigma I want to just let everyone know we're going to shortly get to the Q&A that you've been sharing, so thank you. If you have a question feel free to put it in the chat, I'm sorry, in the Q&A box and we will definitely get to those. We're going to stop and hear from Tammy and Nikki around the stigma and some of the historical injustices and systemic racism that we know exist. And how can you actually work past that to build trust? And if you have any examples that you've seen have worked well in your space, I know the Black Women's Health Imperative has been a leader in this area, bringing in trusted voices and other initiatives. But do you have any thoughts or things that you've seen promising this year?

**Boyd:** I'm assuming it's for me. Yes. In short Black Women's Health Imperative we have really been working to educate around as we've heard already from many of the other panelists, recognizing obesity as a chronic disease and just educating or using the first person language so that we are not creating stigma and bias for individuals that suffer from obesity. And so we have a really exciting initiative that we are in the process, we've been working on for the last few months. And I guess, to back up, yes, trusted messengers are very key. I mean, we just talked about the vaccine allocations and the folks who suffer from obesity being able to get in front of the lines of the vaccine.

And what we've seen there is that trusted messengers are key in the community. For example, Black Women's Health Imperative, Dr. Stanford having … into the Black community and medical schools just really being a part of that. And so Black Women's Health Imperative has teamed up and we're...
really excited about it with helping women, there are leading women's health experts and commenced a partnership to raise awareness of obesity as a disease in a national health crisis in a manner that's free of stigma, judgment and bias.

It's called and we've developed, it's called Reclaim Your Wellness. It's a multifaceted, multicultural campaign which will focus on making obesity a health care priority while improving the lives of people with obesity, changing how the world sees them, prevent and treat obesity as a disease and ensuring that people living with obesity have access to science-based comprehensive care. And we're delivering tailored educational and lifestyle content and resources along with interactive tools, podcasts and stories for real women on the physical and emotional impacts of obesity.

We also convened a webinar series—which Dr. Stanford and Joe participated in—which has been very successful, with a webinar series with experts to elevate the conversation. Again, we also had exciting fitness information and healthy cooking sessions, as well, again, as really focusing on the continuum of care. And we most recently held one and we had a Reclaim Your Wellness program around when diet and exercise are not meeting your goals. And so, we have really sometimes a difficult conversation with Black community about what are your other options and focusing on that and sort of shifting the conversation. But yes, we found that this has worked really well and had great response, and we're looking forward to continuing the Reclaim Your Wellness campaign.

Thompson: Well, thank you. That was comprehensive and, at the end, we'll share a little bit more on how people can connect with you and learn where to find some of these tools. I have seen this on social media, I've seen it in articles about BMI. So is BMI correct for women of color? And it says, "I know personally the weight they have for me to be within their guidelines is putting me at a size three, this is not good." I'm not sure if Dr. Fatima would like to start or if anyone else would want to—

Dr. Stanford: Oh, I am ready. I was ready before you finished the question. I actually redrew the BMI lines in May of 2019 in the Mayo Clinic Proceedings, where I actually utilized data from the National Health Nutrition Examination Survey to see what the BMI cutoffs would be for example, for Black women, white women, Hispanic women. I mean, actually believe it or not, for Black women the BMI cutoff does shift up a little bit. I noticed I said a little bit so somewhere usually on the order between 31 and 33. Using BMI criteria, a BMI greater than or equal to 30 is characterized by obesity so I wanted to redraw these.

I want us to give the historical perspective of the BMI charts. It was developed based upon the Metropolitan Life Insurance tables from the 1930s. And those BMI charts did not include people that look like me or many of us that are on this panel today and so I wanted to see how much it shifts. Now, notice I said 31 to 33 so not major shifts. I think there are a few key things that I want you to know when you're working with your doctors and my patients will universally tell you this. I never, ever, ever give them a target weight. Let me tell you they try, they may have been with me for 10 years now. "Well, Dr. Stanford, what weight should I be?" I will not give you a target weight because...
it's about you reaching the happiest, healthiest weight for you.

Okay, that's extremely important and that's for you, not your sister or your brother because I also take care of a lot of families and you try to compare within your family how one person did with X strategy. It's the happiest, healthiest weight for you. We should use a lot of different factors. Yes, are we paying attention to weight? Am I looking at percent change over time? Absolutely. But we should be paying attention to where that weight is distributed, that's even more important. If it's around our midsection it's around all of our important organs, like our liver, our heart, et cetera, so we want to pay more attention. I will give you a target waist circumference.

And in terms of measuring, you want to measure at the umbilicus or the belly button, umbilicus sounds really smart, but at your belly button. Tape measure around the circumference, and we do have target weight circumference for women, 35 inches or less. For men, 40 inches or less. Let's combine that with looking at something like weight status. BMI is the population-wide measure but like you said it doesn't completely take into account the differences and the nuances. What we do know about Black women and Black men even is that we carry more subcutaneous adipose tissue, more stored in the hip buttock and thigh region. So there is an actual genetic difference that we see when we look at studies that start in children, adolescents, and go into adulthood, differences where fattest positioned.

So it's not just that number on the scale, please don't go by a target number that you need to get to, to fit into some box, it's about getting to the happiest, healthiest weight for you. Hopefully that gives you my thoughts on BMI and not being the end-all be-all for how we evaluate patients in terms of avoiding obesity.

Thompson: Thank you.

Nadglowski: Yep. I think the only thing I'll add, and I agree with everything that Dr. Stanford said, but just something that I like to reinforce to folks is that it is your health care provider's job to diagnose you with obesity. Just because we have BMI charts, I do not believe people should be self-diagnosing themselves with obesity, let your health care provider do that. The definition of obesity is having extra adiposity or body fat that harms your health. You need your health care provider as part of that conversation. So just a warning, I think a lot of people have the tendency to look at that and they diagnose themselves and then they don't go ask for that help again. I think you have to engage your health care provider about that topic.

Thompson: Excellent. Nikki, were you wanting to weigh in as well?

Massie: Yeah. I just wanted to weigh in because the part of that question was something about if I was the current BMI according to the scale, I would be a size three and that's not good. And that's also something that ... obviously this is not scientific, this is just anecdotal but I speak to lots and lots and lots and lots and lots of folks like myself every single day. And one trend that I have tended to
notice is that, and this was even a trend with me when I think to before I had weight loss surgeries, that I didn't have the same desires and expectations as I've seen a lot of, particularly white women, express in losing weight.

When I speak to white women who have had weight loss surgery you tend to hear that they want to be like a size two or size four or whatever. I think the lowest size going in, and this is something I actively ask people in my Facebook group, there’s a couple of thousand people in there, "What do you want? What do you want to expect to happen as a result of your weight loss surgery?" I think the lowest size, clothing size I hear Black women tends to say is maybe size 12. And then what I also see on the other end is when we're losing weight after weight loss surgery, we start to really freak out that we're going to get too small. And some women deal with that with their doctors, some women deal with that by trying to slow down the weight loss ourselves by whatever means we know how to do that.

But to me all of that says and it sort of agrees with my cultural experience that weight was not presented to me as quite the same thing as the mainstream media. I was never expected to look like a Barbie doll, my mom very much railed against that sort of imagery. But also, in my community, women with the big hips, the big backside, the ample chest—these women were celebrated and lifted up and this is really beautiful. As a result of that I feel a lot of Black women don't have that same, that's why I'm a big advocate of talking about the health aspect of it because you may not want to get down to a size three but there may be a size for you where it's the tipping point for your diabetes or your blood pressure or whatever. And like Dr. Stanford said that whatever healthy weight for you even if it may be is a little smaller than what you originally went in wanting to be.

**Thompson:** Thank you. This is amazing, I love having that intersection of voices because we are going to have different perspectives. And this question actually probably will have the same level of different perspectives but it's about obesity being a challenge. And it says, "Unless we address mental health trauma that Black women face, eating is often a drug of choice regardless of the socioeconomic and educational status of many of our women. Have the panelists focused on mental health as a key driver of obesity in our community?" I'll open this up and see if anyone wants to weigh in on this.

**Dr. Stanford:** Yeah. Now, I want to jump in because that's just what I do. All of you that know me on this panel know me well that, that's what I do. But when we address comprehensive treatment to obesity in a tertiary level care center, our center involves the following in your initial workup. Every single patient that we see over the age of 10 meets with an obesity medicine physician like myself, a psychologist that's specifically trained in obesity and a dietician, and we make up your initial team. Each of those visits are an hour in length to delve into each of those components, really addressing the question of mental health concerns.

Often mental health is a huge component but it's not just the mental health in terms of the trauma or racism that people experience, it may be even the drivers of some of the medications that we as docs
prescribe leading to significant weight gain. We know that several of the medications that are used to treat mood disorders, that are used to treat antipsychotic or antipsychotic drugs can cause significant amount of weight gain. I've seen upwards of 80 to 100 pounds from medications prescribed alone for mental health conditions cause that degree of weight gain.

I have a little anecdote when I think about my hairstylist here, I'm in Boston, and I went in to see her and they have you captive while they're doing your hair. I mean, she was talking to me about she gained some weight. And so she was like, "Yeah, I started on this new medication." She has started a drug called mirtazapine and I was like, "Well, why did they start that one for you?" And she was like, "For my depression." I was like, "Yeah, but that one is likely to cause weight gain." I wrote down on a sheet of paper for her to go to her doctor and have a shift to another drug called bupropion. And when I came back to the hair salon, she'd lost 18 pounds.

Now, I really think my hair ... I should have gotten it done for free, don't you guys think? Because that was free advice. But it shows you how we really need to think about all aspects of the mental health of a patient including the medications that we may be prescribing which are contributing to excess weight. I have a lot to say there, I'm going to stop so that my other co-panelists can speak but we do need to be addressing that issue and it's important to do so and we believe with every single patient, whether you're a pediatric or adult patient.

**Thompson:** Is there a space to integrate several facets of medicine? So the intersection again of primary care physicians, therapists, nutritionists, fitness professionals, et cetera, to build a comprehensive resource network for patients. I'm not sure if there's some examples or evidence-based examples that you can speak to, but I'm not sure Dr. Cody, Fatima Cody Stanford, if this will be back to you or if Joe, you have an example that you'd like to highlight as well.

**Nadglowski:** Well, I can just mention that I think that the goal is I think for us to have more of these comprehensive management programs like Dr. Stanford's and there are just a handful across the country. What they're asking for ... okay, you have primary care, you have therapists, you have nutrition, you have fitness, all of that together I think ultimately is the goal. The coast is actually we've come to that is in bariatric surgery where they have these comprehensive programs that are like that and I think that the goal now is to move us towards a model where you have overall obesity medicine doing the same thing. I know a couple of the insurers are playing with it. We'll see what happens over time but I'm hoping when we talk again next year, we might have a little more information on where there can you can find resources about those comprehensive programs.

**Thompson:** What community grants exist that community and faith-based organizations can access to help fund their activities. Does anyone have any insight on resources here?

**Nadglowski:** I can tap in there too—
Dr. Stanford: Yeah, Joe, you go. You go first, you go first, yeah.

Nadglowski: I think the main source of a lot of this funding is our friends at the Centers for Disease Control and I just want to point out something that's very much a positive. So last year, they put $3 million in the budget for some social determinants of health work around chronic disease prevention. And we were excited because it was zero before that and we were excited. And then as a community we were going to say, "Well, let's put 50 million in this year," and then the president actually released his budget and he put 153 million in, so we had to revise all our letters.

But I think in fiscal year '22 proposed budget, there's actually a lot more resources being allocated in this space. So assuming that that moves through and ultimately passes, and obviously there's always challenges with that, but there's probably an opportunity for a great deal more funding especially around linking the social determinants of health issues with obesity. I think there's a lot of potential there.

Thompson: Excellent. another question regarding the shifts in school, around home economic classes and generations that may not know how to cook and therefore depending on fast food. Does anyone have any thoughts on home economic and physical education revamping that's needed?

Massie: I will say that I came from the generation of kids who still had home ec. I didn't learn to cook significantly. I learned to cook from my mom and in many ways, and this is just my experience, I don't want to say this is emblematic of anybody else's experience, but I was really lost when I started to try better methods of cooking, better quality of food. I did not like for example, was fish. I didn't know how to cook fish if I wasn't frying it because that's how I was taught to cook fish.

It did take a little bit of education. I ended up founding a website called Bariatric Foodie and our motto is “Play with your food." And that was really my way of saying, "Hey, I'm new to this, you're new to this. Let's go on this adventure." Because there's so many people who are my age and older, and the following up my blog is actually my age and older, it's 45 to 65. And we all had home ec and we still sort of have trouble with the cooking component of it.

But the other thing I wanted to weigh in and say is that in my day job, I work for an organization, part of what they do is sustainable development around the world. And one of the ways that we've long since accepted that we have to address food security is not only in the introduction of healthier crops but then you also have to come in and help people know what to do with those healthier crops.

In parts of Africa, they've introduced certain sweet potatoes that are very nutrient rich for young children but if the parents don't know how to prepare them, or culturally this is a food we're introducing that wasn't a part of your culture before and you weren't taught how to eat that way, there's that component. I think the same thing is true in the United States. I think home economics can be if a curriculum is developed that focuses on what people need to know about cooking.
healthfully as opposed to, this is a pot and this is what kind of knife this is and all that good stuff.

**Thompson:** Well, thank you so much for weighing in on that, on Nikki's. And Dr. Fatima, can you take us home with your closing thought?

**Dr. Stanford:** Absolutely. I think the key thing that we want to note from all of the different perspectives is that number one, obesity is a disease. It's a real disease, it warrants treatment, it warrants care, it's particularly needed within communities of color due to these disparities that exist. I'm committed to this work on all fronts, from the research to the policy, to the advocacy, working with OAC, working with Tammy with Black Women's Health Imperative. Having my girl, Nikki, work through what it's like to be a patient having overweight and obesity, and I think we need to hear all of these voices.

**Thompson:** Well, thank you for everyone for joining us. You brought so much richness to the conversation. we look forward to advancing this goal to end obesity disparities. Be well.

**Unger:** I'm Todd Unger, and this is Moving Medicine—a podcast by the American Medical Association. This episode was originally a panel session as part of the 2021 National Minority Quality Forum’s Annual Leadership Summit on Health Disparities and Health Braintrust.

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