Obesity has gained further attention during the COVID-19 pandemic, creating a greater need to rethink how this disease is viewed and treated. But while progress has been made to understand obesity better, discussing weight with a physician and their care team remains challenging for patients.

That is why it is time to start the conversation about how to support patients in making sustainable lifestyle and behavioral changes. Knowing what steps physicians, care teams, and organizations should take can help provide better care for patients with obesity.

Many years ago, Francine Kaufman, MD, former president of the American Diabetes Association, coined the term “diabesity,” AMA member Fatima Cody Stanford, MD, MPH, MPA, an obesity medicine physician and associate professor of medicine and pediatrics at Harvard Medical School, said during a webinar co-hosted by the AMA, American College of Preventive Medicine, and the Black Women’s Health Imperative about how to help patients with obesity get evidence-based treatment and make lifestyle changes.

“We must recognize that 80% of those with type 2 diabetes also have the disease of obesity,” said Dr. Stanford, noting that “80% is a sizeable number and what we are seeing in the endocrine space—and I would say even in the cardiometabolic health space altogether—is this recognition that if we treat obesity as a disease, we affect downstream impacts including diabetes within that treatment scope.”

During the webinar, Dr. Stanford shared some areas physicians, and their care teams can focus on to improve care for patients with obesity.

1. **Recognize obesity as a disease**
“People often understand or have a general understanding of diabetes. They don’t know this concept of obesity as a disease,” said Dr. Stanford. “When working with patients, my goal is to get you to the healthiest weight and what aesthetics goes with that. I tell them by using certain modalities, we’re able to address both concurrently and have a huge impact on not only their morbidity but also increase their life expectancy.”

“Then I start explaining obesity is a disease of the brain and how it interrelates to the regulation between the pancreas, which of course is the organ that produces that insulin that keeps our blood sugar normal,” she said. “I’m able to, over time—maybe not all in the first visit—begin to get them to understand how these two go together and how the work we do together will address both.”

Don’t play the shame game

“We have to be careful about even how we’re labeling our charts before the patient gets in the door. So, there are a few ICD-10 codes, for example, that are out there that I will never use,” said Dr. Stanford. For example, “morbid obesity. We don’t call it morbid cancer. We don’t call it morbid COVID-19. We don’t call it morbid heart disease. So why call it morbid obesity? The language in and of itself is stigmatizing.”

“Don’t say: I don’t know if you’ve been eating well. You’ve been telling me you’ve been doing this or tried these diets, but are you sticking to them correctly?” she said. “Imagine if you put yourself in that person’s shoes what that feels like. There’s a sense of me needing to defend myself as the patient against you, the bad person who becomes increasingly villainous the more you talk about it because you haven’t recognized or tried to understand why they have struggled with their weight.”

Maintain weight with physical activity

“We sell the wrong messaging with regards to physical activity,” said Dr. Stanford, noting that on the first of every year, most people decide to join the gym “for the sole reason of losing weight, which is usually the No. 1 resolution people make. So, they go to the gym, and they’re going hard for January, and then the end of January approaches, and they realize the scale hasn’t moved at all.”
“But the messaging we’ve sold to people is that they need to exercise to lose weight when it is not necessarily a great tool for weight loss. So, wonderful tool, but for weight maintenance,” she said. “You go to the gym so that you don’t gain the five or 10 pounds that you might have been gaining all of your adult life so that we can help maintain your weight.”

“We need to be selling the right messaging because physical activity is a huge and important part of this lifestyle piece of the puzzle,” she said.

4 Don’t rely on BMI as a diagnostic tool

“When you’re looking at that chart, and you see that body mass index or BMI, that is a screening tool, but not a diagnostic tool,” Dr. Stanford said, noting it was initially drawn from actuarial data among white people from the 1930s from Metropolitan Life Insurance Co.

“Significant data shows that different groups have different BMI cutoffs by which we need to pay attention to,” she said. “When that patient is in front of me, I want to look below the skin’s surface. We must ensure we’re not disregarding those individuals because of our biases towards those who carry excess weight.”

5 Encourage healthy habits for life

“One of our programs, for example, that I’ve published is called Healthy Habits for Life,” said Dr. Stanford. “The goal is for us to ... teach them things that can be sustained long-term, not acute, quick fixes that will drive weight down.”

“The Healthy Habits for Life program is a 12-week program run by our dietitians teaching things like volumetric, using high-water content to feel full longer to use over the life course— not just for that 12-week period that you’re going through the program,” she said.

A healthy way for patients to lose weight and make appropriate lifestyle changes is through participation in a National Diabetes Prevention Program (National DPP) lifestyle change program. The AMA’s Diabetes Prevention Guide supports physicians, care teams and health care organizations in defining and implementing evidence-based diabetes prevention strategies.