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A Patient-Centered Approach to Obesity Management

Dr. Buch:
Welcome to ReachMD. I'm Dr. Peter Buch, and today I'm joined by Ted Kyle to explore how we can improve care for patients with obesity. Mr. Kyle is the Founder of ConscienHealth and the Policy and Advocacy Advisor to the Obesity Society. He's also the Past Chair of the Obesity Action Coalition. Welcome to the program, Mr. Kyle. I'm looking forward to our discussion.

Ted Kyle:
Thank you so much for the invitation.

Dr. Buch:
If we start with the big picture, what makes obesity such a complex condition?

Ted Kyle:
First of all, the physiology of this condition is exceedingly complex. But what makes it even worse is the fact that most people assume that it's relatively simple. How much did you eat? How much do you move? And what's the calorie surplus that you're consuming? Research and the science of obesity has told us that that really is terribly misleading.

Dr. Buch:
And a big challenge is the perception that obesity is simply self-inflicted. How can we improve beyond that stigma and foster a more accurate understanding of obesity?

Ted Kyle:
Well, this has been a problem, really, for as long as I've worked in this field, and I've worked in this field for close to a quarter century. The assumption is that it's a simple matter of calories in and calories out, when, in fact, obesity is a matter of the dysfunction of many, many physiologic systems of the body that regulate metabolic health. So the idea that it's self-inflicted is a terrible mistake. It's not a common one, and it's one that we're already overcoming.

And when I say we're overcoming it, I just reflect on the remarkable progress we've seen in the last, I'd say, five years really, where there are medicines now that correct some of these physiologic dysfunctions that cause obesity. People intuitively see that, wow, if medicine fixes this, then it must be a medical condition that, indeed, people did not choose for themselves. We don't think about people choosing cancer for themselves, or diabetes, or high blood pressure. We know that physiology is at work. Just like any other condition, yes, you can make choices that make it better or worse, but the fact is that your physiology sets the table for obesity, the environment serves it up, and then you get a choice of what to do about it.

Dr. Buch:
And as a follow-up question to that, Mr. Kyle, what percentage of the American population is currently on GLP-1 agonists for weight loss?

Ted Kyle:
There is some survey data by Gallup that suggests that it's in the range of 10 to 15 percent of people that are currently using GLP-1 medicines, which is startling to some people, but to others, when they reflect on the fact that 75 percent of the population is living either with overweight or obesity, it's not all that surprising.

Dr. Buch:
And what's the projected growth rate for the GLP-1 agonists and similar congeners?

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Ted Kyle:
There are all kinds of projections out there, and it is forecast to become a category that will surpass the size of the market for cardiovascular therapies and so forth. And it's not entirely surprising, when you think about the fact that obesity is at the root of many of the chronic diseases that we live with and that our health systems pay for the treatment of, ranging from cardiovascular disease to diabetes to renal disease to liver disease to certain forms of cancer, to sleep apnea, to musculoskeletal disease—and the list really goes on and on. There are any number of things.

The problem is that it's taking time for the health systems to adapt to that idea that, oh, wow, we can deal with these chronic diseases by tracing them back to their roots with obesity and doing a better job of treating obesity. That takes time for everybody to wrap their head around.

Dr. Buch:
And one additional question is cost. Do you foresee that costs are going to be under control in years to come?

Ted Kyle:
People are having trouble getting their heads around this, simply because we have dug ourselves into a very deep hole with chronic diseases. The prevalence of cardiovascular disease—of all of these conditions that result from untreated obesity—is very high, and we're spending a lot of money on treating those conditions in the people who never got adequate treatment for obesity. And, at the same time, we're trying to figure out how we can treat these people with obesity so that the burden of those diseases does not continue to grow. Well, you're doing double duty. You're trying to, let's just say, fix the roof while it's raining. And that gets hard.

However, what I will say is that there's been modeling done and there's personal experience for so many people who see their health dramatically improve when they receive therapy, and that suggests that yes, indeed, it can be more efficient to treat obesity than to let it go untreated and treat all the complications.

In addition to that, what I can say is the costs of these drugs have come down dramatically since they were first introduced, and we anticipate further decline in those costs. In fact, some of the modeling that has been done suggests that these will not only be cost-effective, but cost-saving over time.

Dr. Buch:
That's wonderful to hear. So how can bias show up among providers in the clinic, and what can we do to reduce this bias?

Ted Kyle:
Well, you alluded to it when you talked about the tendency to think about this condition as something that is self-inflicted. And what happens is that people commonly presume—and they used to say it out loud—that you did this to yourself, now go away and fix it. Come back to me when you have lost weight.

Where we are today is that research shows us that explicit bias—those awful, stigmatizing things that physicians and other healthcare providers used to say out loud—are now less common than they were just 10 years ago. But the implicit bias—the assumptions that people make and the thoughts that people have that might never get expressed—is still very common. And so bias and stigma make a big difference.

In answer to your question, how can we reduce it? One is to be aware of it and to examine one's own bias. Another thing is to make a practice of and make an effort to listen to people living with obesity, and meet them where they are. I have found that the biggest difference in trying to reduce bias and stigma is to put people face to face in give-and-take relationships with people who have lived all their life with obesity, so that they understand the true impact of that condition and what it is, and don't live with these presumptions that they have about people that they've never met.

Dr. Buch:
For those just joining us, you're listening to ReachMD. I'm Dr. Peter Buch, and I'm discussing opportunities to improve obesity care with Ted Kyle.

So let's move on. The availability of GLP-1 based therapies has changed the conversation around obesity treatment. In this evolving landscape, how can clinicians keep patients actively engaged in their care and ensure that treatment remains a partnership?

Ted Kyle:
I think the critical concept here is shared decision-making. One of the most eminent people in this field, Dr. Gary Foster, once told me—and it stuck with me for now 20 years—that when you're talking to someone who's living with obesity, and you're doing half of the talking, you're talking too much. And that is because of the intensely personal and very different nature in every person living with

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obesity. And so it's really that give-and-take relationship where you really are meeting people where they are and engaged in shared decision-making.

Now, that's easy for me to say. The reality of health systems and healthcare, particularly primary care, is such that give-and-take conversations are not so easy. It requires a readjustment to figure out, how am I going to find time? How am I going to find a financially viable way to commit the time to an interaction with a person living with obesity? Because it's not a subject that you can just give a quick soundbite to, move on, and be done. It requires dialogue, which requires time, which requires careful attention to how the visits are scheduled, coded, and realistically reimbursable, so that you're not just burning up time that you'll never get paid for.

Dr. Buch:
So a caveat to all of that is that some patients just assume that the GLP-1 agonists are all they need to do. So how can we get patients beyond that point and engaged in that process? Specifically, what do we need to do?

Ted Kyle:
We live in an age of direct-to-consumer advertising for pharmaceuticals, and yes, it's true that people are bombarded with messages that say, "Ask your doctor about this or that new medicine, and the doctor will give you the medicine and life will be good." So that's a very human response. And obesity is not like that. These medicines are not magic. They do require more than just a prescription. So it requires, again, that give-and-take interaction.

The other thing I would say, though, is that it's not entirely unreasonable for a person who has lived with this condition all their life and encountered healthcare providers who tell them, "Just go on this or that diet. Your problem will be solved. Go take care of it," to be conditioned to expect that providers would just tell them, "Do this," and that's all we need to think about. And so hearing that there are medicines that are marvelously effective and knowing that they don't get a lot of helpful information from a typical provider might lead them to say, "Well, all I'm going to get out of this person is a prescription. So if I can just get that, that's a win, and I'll move on and do what I can and seek support from peers and from the web and from TikTok or whatever." It's not ideal, but it is understandable.

And so, really, the answer of how you get past that is by establishing a rapport with a patient and having give-and-take shared decision-making, where you really work with a patient to help them get to their goals. One of the experienced obesity medicine providers that I work with said something that's very memorable, and that is, "I tell my patients this is not going to be easy, that this is a chronic condition that they will be living with for the rest of their life, but we can succeed. And as long as you stick with me, I'm going to stick with you."

Dr. Buch:
I love that. We have only a few remaining minutes to discuss. Do you have any additional thoughts you'd like to share with us today?

Ted Kyle:
I just really want to come back to this idea that obesity is complex. People are fond of thinking that, "This is just a problem of a bad food supply. Ultra-processed foods have made us all fat, and it's as simple as that." Unfortunately, it's not as simple as that. Certainly, there are problems with the food supply, but there are other problems in our environment that have brought us an excess of obesity.

There is the physical and technological environment that has us spending our days in front of a screen. There is the exposure to chemicals and drugs in our environment that we don't choose, but that disrupt our endocrine system. And over a lifetime, the effect of that can be profound. And these are endocrine-disrupting chemicals. These are drugs that cause weight gain, that, by and large, have not been paid the due attention that they deserve. And then there are stresses and stressors in our environment, like economic stress and social stress, and these different forms of stress—and that would include stigma attached to obesity—have the effect of causing a stress response that actually causes weight gain. All of those factors interact. There are complex, inter-adaptive systems that interact with each other to make a wicked problem, and it's not one that's easy to solve.

Dr. Buch:
Mr. Kyle, thanks so much for sharing some really important insights.

Ted Kyle:
It was a pleasure to be here and to chat with you a little bit.

Dr. Buch:
For ReachMD, I'm Dr. Peter Buch. To access this and other episodes in this series, visit ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening, and looking forward to learning with you again very soon.

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