My Weight Loss Journey and The Importance of Obesity Education in Medical School

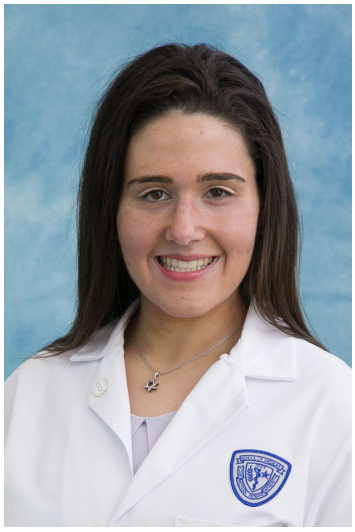
By Amber Olson, Medical Student


I am a medical student who has been battling the disease of obesity for more than 10 years. I have viscerally experienced the perspective of a patient with obesity in our health care system: the defeat after being repeatedly told to exercise more and eat less, the embarrassing glares of judgment, and the shame after being squeezed into chairs, blood pressure cuffs, gowns, and tables. I was fortunate to seek help from Dr. Pannain and her team at Chicago Weight, who helped me lose 100 pounds through lifestyle changes and medication. I used to have chronic fatigue, pre-diabetes, and pre-hypertension. With the weight loss, all of these conditions were resolved.

My experiences struggling with obesity have framed my motivations to improve the landscape of obesity care as a physician. When I arrived at medical school, it became abundantly clear how little attention is paid to the disease of obesity in medical curricula across the country. Although the American Medical Association (AMA) declared obesity a disease in 2013, medical education has been resistant to teaching it as such. Obesity affects at least 42.4% of the population and results in at least $170 billion of excess health care costs, yet physicians report they are not equipped to treat it. And in one survey study, only 10% of medical schools reported that their students are “very prepared” to treat patients with obesity. In the health care field, we are skilled at educating future physicians about chronic diseases like diabetes and hypertension — but not the most prevalent one, obesity. Medical education has also taken constructive steps to change attitudes and approaches to the care of other stigmatized diseases, such as substance use

disorder, yet obesity is still too often attributed to a lack of willpower or moral failing. This educational gap has and will continue to have consequences on the treatment of obesity unless we decide to make a change. When individuals are blamed for their disease, they are less likely to seek medical treatment. Even if treatment is sought, the quality of care received is often lower compared to individuals without obesity. As many physicians too often attribute obesity to the patient “eating too much and moving too little,” the health care setting can be a hostile and ineffective environment for patients with obesity.

The last couple of years has revealed the consequences of deprioritizing obesity education among our current and future caregivers. During the COVID-19 pandemic, the medical community observed firsthand that obesity is not just a risk factor for COVID-19, but a chronic, inflammatory disease that interacts at the biological level with other disease processes. Obesity increases the risk of contracting COVID-19 by 46%, the risk of hospitalization by 113%, the risk of ICU admission by 74%, and the risk of mortality by 48%. More lives may have been saved had we had a stronger foundation in obesity, obesity management, and weight bias prior to the pandemic.



This year, I was able to spearhead the creation of two brand-new seminars on obesity pathogenesis and treatment for M1 students at Case Western Reserve University School of Medicine. These students' new understanding of obesity as a chronic disease that can be treated will help inform their future practices in terms of both interacting with and treating patients with obesity. Skilled obesity management may be an essential step toward minimizing the impact of future pandemics. Against the backdrop of a pandemic that was particularly dangerous for individuals with obesity, we have entered a new era of anti-obesity pharmaceuticals. We have developed both safe and effective drugs that target appetite regulation and digestion. Semaglutide, a GLP-1 agonist, was approved by the FDA in June 2021 for the treatment of obesity. Its clinical trials demonstrated a mean bodyweight reduction of 15%. A recent phase 2

trial for an amylin analog, Cagrilintide, also shows promising results. However, anti-obesity pharmaceuticals are not routinely taught at the medical school level, perhaps due to the myth that obesity is the result of lifestyle choices. When medical providers are not well-versed in the tiers of obesity treatment — including behavior modifications, anti-obesity pharmaceuticals, and bariatric surgery — patients will not be able to benefit from these treatments.

The time is now to prioritize obesity education in medical school. Obesity is a chronic, progressive, and complicated disease state. Obesity education requires an understanding of the complex pathophysiology and etiologies of obesity, its disparities, its stigmas, its treatment, and its related comorbidities. We are living through a pandemic that has unequally affected those with obesity, while innovative obesity treatment options continue to be developed. Prioritizing obesity education at all levels of medical education will stimulate research and development toward innovative obesity treatments while reducing the weight bias that permeates health care settings. This is essential if we have any chance at tackling obesity's rising prevalence and its effect on individuals, families, and communities.

I experienced a lot of distance between me and my physicians because of my size. As a physician, I would like to bridge that gap for my patients and encourage other physicians to do the same.