UNIVERSITY OF LEEDS

Article:
Le Brocq, S, Clare, K, Bryant, M orcid.org/0000-0001-7690-4098 et al. (2 more authors) (2020) Obesity and COVID-19: a call for action from people living with obesity. The Lancet Diabetes & Endocrinology, 8 (8). pp. 652-654. ISSN 2213-8587

https://doi.org/10.1016/s2213-8587(20)30236-9

Obesity and COVID-19: A call for action from the perspectives of people living with obesity during the peak of the COVID-19 pandemic

Le Brocq S [1], Clare K [1,2], Bryant M[3,4], Roberts K[5], and Tahrani AA*[6] on behalf of the writing group form Obesity UK, the Obesity Empowerment Network and the UK Association for the Study of Obesity (ASO).

[1] Obesity UK https://www.obesityuk.org.uk/

[2] Obesity Empowerment Network https://oen.org.uk

[3] Association for the Study of Obesity (ASO), https://www.aso.org.uk

[4] ASO Chair; Associate Professor, CTRU, University of Leeds, UK, LS29JT m.j.bryant@leeds.ac.uk

[5] ASO Trustee; Public Health Nutritionist, The University of Sheffield, S1 4DA, katharine.roberts@sheffield.ac.uk

[6] Senior Lecturer in Endocrinology and Obesity Medicine, University of Birmingham, Birmingham UK, B15 2TT. Honorary Consultant in Obesity, Diabetes and Endocrinology at University Hospitals Birmingham, NHS Foundation Trust, B15 2TH, Centre of Endocrinology, Diabetes and Metabolism (CEDAM), Birmingham Health Partners, Birmingham B15 2TH, UK.

* Corresponding author: a.a.tahrani@bham.ac.uk

Word count: 1003 words. Tables: 1 (Supplementary file)

Data from France and the UK showed a disproportionately higher prevalence of obesity in patients with COVID-19 admitted to Intensive Care Units (ICU) compared to general population data (1, 2). Approximately 10% of ICU patients in the UK have a BMI ≥40 kg/m^2 and evidence shows increased mortality amongst this group (2, 3). The UK Government advice for those with a BMI ≥40 kg/m^2 is to be 'particularly stringent following social distancing measures'. This has created confusion and fear amongst many people living with obesity due to an uncertainty about their risk or what actions they should take, including those with a BMI ≥30 kg/m^2, who are also over-represented in ICU, but not listed as 'at risk' (3).

We consulted with people living with obesity and here, we summarise the main reflections, formulated into a call for action (see supplement material and Table 1). It is a candid account of the impact of COVID-19 during the peak of the pandemic in the UK. Reported effects were both physical and mental and are likely to have a lasting impact for many years to come.

Overwhelmingly, we heard of genuine, all-consuming fears of contracting COVID-19, with many people afraid of not getting medical support if they are admitted to hospital and the accumulating reports that they are at greater risk of dying. Clearly, there is an immediate need for clarity regarding risk, both in terms of contracting the virus and for its likely impact. .

There was considerable anxiety about the capacity of the healthcare system to provide appropriate equipment, gowns and beds. Anxiety about accessing healthcare is not a new phenomenon (4) but is likely to be exposed during the current crisis. From the perspective of Obesity UK and Obesity Empowerment Network (OEN) members, this not only represents a physical challenge, but one of dignity if they become hospitalised. These fears are not without cause; patients who require sedation do need to be moved and proning appears to be important in the successful treatment of acute respiratory distress (5). There is also a fear that access to obesity treatments (particularly NHS multidisciplinary therapy and bariatric surgery) will be affected by austerity policies in response to the economic crisis at a time of increased demand .

Another recurring theme was stigma, largely related to comments on social media and fuelled by the media. We suggest that media speculation is underpinned by societal norms permitting the

discussion and referencing of body shape and size by anyone; perpetuating existing stigma. Many expressed that this led to feelings of shame, a perception of being "*less of a priority than any other condition*" and a reluctance to seek help. Respondents were acutely aware of the impact that language has on stigma, with many citing the poor use of "*unscientific*" words. This is not new to COVID-19 but has been exacerbated during this time (6). Stigma has a lasting and negative impact on the mental and physical health of people living with obesity (7). It can be conscious or unconscious and delivered from multiple sources including health professionals (6). One consequence can be an avoidance of healthcare; likely worsening COVID-19 outcomes. Obesity UK, some Royal Colleges, charities, advocacy groups, clinicians and patients have been striving hard for many years to reduce weight stigma and guidance and position statements are available (6, 8).

In every response, we learnt about mental health concerns. Though some of these were linked to the fear of contracting COVID-19, many related to the impact of isolation, shielding or social distancing. Resilience appears to relate to mental health prior to lock-down; those who reported coping better often expressed that they were in a "*good place mentally*" before COVID-19 outbreak. Worryingly, this is not the case for many, particularly those who have recently undergone (or are waiting for) bariatric surgery. Lock-down presents substantial challenges to maintaining healthy behaviours for anyone; however, people living with obesity have often experienced years battling with weight and experiencing feelings of guilt from perceived failure (9). Representatives in our consultation reported having a fear of weight gain during lock-down,expressed through the impact of anxiety on eating behaviours (often compounded by scrutiny from family members). For many, this related to stigma or shame, also preventing them from exercising or shopping for food in ways that did not make them feel self-conscious. Lock-down has had a profound influence on self-efficacy, and increased episodes of secret eating or binge eating has been commonly reported within the Obesity UK support groups during this time. Like many stigmatised populations, people living with obesity have often developed coping strategies over many years (10) and this was highlighted in our consultation. Many reported using

focused and dedicated approaches to protect physical and mental health, including attending remote support groups.

Our calls for action are thus: Immediate action is needed to clarify the risk of adverse COVID-19 outcomes for people living with obesity, with specific recommendations for those at greatest risk and the healthcare professionals who support them. This includes supporting research to define the risk of infection and subsequent mortality in people living with obesity, in addition to providing clear guidance on managing risk. Essential to this is careful consideration of messaging to prevent the perpetuation and exacerbation of stigma. Long-term, the current pandemic offers an opportunity to consider ways to improve the healthcare system for people living with obesity and tackle obesity related stigma. In addition to providing appropriate equipment, we advocate specific training for health care professionals which empowers them to support people living with obesity, minimise unconscious bias and prevent stigma While we welcome the recent UK Government focus on obesity, any action must be considered in the context of the experiences of people living with obesity and an understanding of obesity as a complex chronic disease. Accordingly, we call on the UK Governments to work with people living with obesity when developing guidance and COVID-19 recovery plans, who are in frequent contact with the healthcare system and have expertise on barriers to accessing healthcare (6)..

References

1. Caussy C, Pattou F, Wallet F, Simon C, Chalopin S, Telliam C, et al. Prevalence of obesity among adult inpatients with COVID-19 in France. The Lancet Diabetes & Endocrinology.8:562-4.

2. Public Health England. Disparities in the risks and outcomes of COVID-19. London; 2020 June: gateway number: GW-1311, URL: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892085/disparities_review.pdf (access date 21.06.20)

3. Flint SW, Tahrani AA. COVID-19 and obesity; lack of clarity, guidance, and implications for care. The Lancet Diabetes & Endocrinology. 2020;8(6):474-5.

4. Wolfenden L, Ezzati M, Larijani B, Dietz W. The challenge for global health systems in preventing and managing obesity. 2019;20(S2):185-93.

5. Henderson WR, Griesdale DEG, Dominelli P, Ronco JJ. Does prone positioning improve oxygenation and reduce mortality in patients with acute respiratory distress syndrome? Can Respir J. 2014;21(4):213-5.

6. Albury C, Strain WD, Brocq SL, Logue J, Lloyd C, Tahrani A. The importance of language in engagement between health-care professionals and people living with obesity: a joint consensus statement. The Lancet Diabetes & Endocrinology. 2020;8(5):447-55.

7. Tomiyama AJ, Carr D, Granberg EM, Major B, Robinson E, Sutin AR, et al. How and why weight stigma drives the obesity 'epidemic' and harms health. BMC medicine. 2018;16(1):123.

8. Rubino F, Puhl RM, Cummings DE, Eckel RH, Ryan DH, Mechanick JI, et al. Joint international consensus statement for ending stigma of obesity. Nature Medicine. 2020;26(4):485-97.

9. Pila E, Sabiston C, Brunet J, Castonguay A, O'Louhglin J. Do body-related shame and guilt mediate the association between weight status and self-esteem? Journal of health psychology. 2015;20.

10. Miller CT, Kaiser CR. A theoretical perspective on coping with stigma. Journal of Social Issues. 2001;57(1):73-92.

Author contributions

The idea was conceived by SLB and MB. SLB led the promotion and gathering of feedback from patient and population groups, supported by KC, PC and AH. SLB, KC, PC, AH and MB interpreted the feedback. All authors contributed to writing the paper, including ensuring data were relevant and up to date.