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Obesity pillars roundtable: Better together - combined obesity medicine and metabolic surgery care for the treatment of obesity

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ABSTRACT

Background: Obesity is a chronic, multifactorial, complex, and relapsing disease typically requiring treatment from various medical providers throughout the continuum of care. A natural overlap in medical and procedural obesity treatment therefore often exists during the course of treatment. Given this, the optimal treatment of the medically complex patient population may best be delivered either within multi-disciplinary teams, or through more effective collaboration with diverse specialists sharing the common interest of managing patients with obesity. The aim of this roundtable is to more deeply engage on issues surrounding the multi-disciplinary approach for the treatment of obesity, along with highlighting areas of opportunity for improving collaborative care.

Methods: This roundtable review includes perspectives from two obesity medicine specialists and two metabolic bariatric surgeons, all with extensive experience in combining medical and surgical care.

Results: While the panelists generally agreed upon core principles of combined obesity medicine and metabolic surgical care for the treatment of obesity, each had their own priorities and approach regarding the best ways to overlap care. Variances in perceptions included importance of procedural care versus use of pharmacotherapy. However, the panelists endorsed more collaborative work as vital for improving outcomes. Further identification of existing barriers and the creation of pathways for action will bring this work forward.

Conclusions: Providing guidance on one universal approach to the care of patients with obesity is challenging due to the heterogeneity of patient populations and variance in practice patterns across the spectrum of care. The panel suggested adopting a continuum-of-care mindset, meaning that all available options should be considered for patients, either in sequence, or as adjuvant therapies, or as rescue options for patients who gain tolerance to a particular therapeutic modality. This approach is in keeping with the reality that obesity is a chronic, relapsing multifactorial disease.

1. Introduction

1.1. Dr. Frederiksen

Hello. My name is Dr. Kirsten Frederiksen. I am the Co-Director of Clinical Education for the Obesity Medicine Association (OMA) and the current Chair of the Bariatric Medical-Surgical Committee of the OMA. For this "Obesity Pillars Roundtable: Better Together - Combined Obesity Medicine and Metabolic Surgery Care for the Treatment of Obesity", I will be serving as moderator.

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We are going to explore how obesity medicine and bariatric surgery can work together more effectively to treat obesity. Providers in obesity medicine (here including endocrinologists) emphasize their vital role in holistic, long-term patient care. On the other hand, bariatric surgeons (here including gastroenterologists) underscore the importance of procedural options for those who qualify.

There has always been a bit of a tug-of-war between these two approaches. Recently, though, the rise of highly effective obesity medications has shifted some focus away from surgery. At the same time, advancements in surgical techniques—now safer and more effective—continue to make surgery a strong option for severe obesity.

In our current healthcare landscape, the lack of collaboration between specialties, inconsistent referral patterns, and spotty insurance coverage—often ignoring evidence-based guidelines—means patients do not always get a unified, patient-centered treatment plan. But there is a glimmer of hope: Emerging is recognition that with a more collaborative approach to care, our current system for treating obesity, in particular those with severe obesity, will produce more optimal outcomes and likely reduce costs [1–6].

Today, we will dive into the latest treatments for obesity and expected outcomes for each. We also wish to explore how obesity medicine and metabolic bariatric procedures intersect to offer the best care, looking at different practice models, the pros and cons of each, and the experience of our panelists working in these various models of care. We will reflect on challenges and opportunities that come with collaboration between obesity medicine and metabolic bariatric care. Finally, each panelist will share some key lessons learned and takeaways and offer recommendations for advancing this collaborative approach—how we can make 'Better Together' really work in practice.

As a disclaimer, the opinions expressed in this roundtable discussion do not reflect any official position of the OMA itself.

I am honored to have 4 leading clinicians with expertise and unique perspectives regarding the treatment of obesity using combined medical and surgical approaches. We will also have an international perspective, with one of our panelists joining us from Nova Scotia. I will start by asking each of you to briefly describe your medical practice and experience.

2. Introduction of expert panelists

2.1. Dr. Frederiksen

Dr. Shetye, can you please summarize your clinical background and current clinical practice setting?

2.2. Dr. Shetye

My name is Dr. Bharti Shetye (also known as Dr. Abby). I am the CEO and owner of Dr. Abby's Weight Management Clinic in Tampa, Florida, the Vice President of the Obesity Medicine Association, ex-officio board member of the Obesity Action Coalition, double-board certified in Obesity Medicine and Internal Medicine, and the Board Liaison for the Bariatric Medical-Surgical Committee of the OMA.

With 20 years of experience as an Obesity Medicine specialist with expertise in collaborative management of the post-bariatric surgical patient, I was honored to present at the International Federation for the Surgery and Other Therapies of Obesity (IFSO) meeting in India in February 2025. I have been the Medical Director of a Bariatric Medical-Surgical clinic for a large corporation and in my current privately owned single specialty clinic, I continue to manage post-bariatric surgical patients.

2.3. Dr. Frederiksen

Dr. Mattar, please summarize your clinical background and current clinical practice setting.

2.4. Dr. Mattar

Hello, I am delighted to be here and participate in this vital endeavor. I have been practicing metabolic bariatric surgery for 25 years and through my academic and society leadership roles, I have had a front seat view of the tumultuous changes that have taken place in our field.

I am the Medical Director of the Weight Management Center at Baylor College of Medicine in Houston, Texas, and am Past-President of the American Society for Metabolic and Bariatric Surgery (ASMBS). My practice is predominantly dedicated to the comprehensive and lifelong care of patients with obesity and metabolic syndrome. I am board certified by the American Board of Surgery with a Focus of Practice Designation in metabolic bariatric surgery (MBS) and am also certified by the American Board of Obesity Medicine, where I have the privilege of sitting on its Board of Directors.

2.5. Dr. Frederiksen

Dr. Jad, please summarize your clinical background and current clinical practice setting.

2.6. Dr. Jad

I am a Bariatric Surgeon based in Truro, Nova Scotia, and fellowship-trained at Laval University in Quebec, Canada. I currently serve as an Assistant Professor of Surgery at Dalhousie University and am a diplomate of the American Board of Obesity Medicine (ABOM).

I am passionate about expanding access to safe, patient-centered obesity care. As Interim Chair of the Bariatric Physicians and Surgeons Section at Doctors Nova Scotia and founder of the Truro Obesity Symposium, I work to bring healthcare professionals together to advance bariatric medicine across Atlantic Canada. I also founded the Truro Obesity Clinic, which offers both medical and surgical services for comprehensive obesity management.

2.7. Dr. Frederiksen

Dr. Berger, please summarize your clinical background and clinical practice setting.

2.8. Dr. Berger

Thank you for having me here today. It is an honor! I am Dr. Reed Berger. I am currently an Associate Clinical Professor of Medicine and Surgery at University of Illinois (UI) Health in Chicago and serve as their Obesity Director. I am board certified in Internal Medicine and Obesity Medicine, and I am a Physician Nutrition Specialist. I have been practicing Obesity Medicine for over 20 years. My specialty is in the care of pre- and post-bariatric surgery patients. I also prescribe and am a proponent of obesity medications to help patients augment their weight loss after surgery.

I work at an academic-based medical center that is state-funded. We serve primarily underprivileged populations. This impacts what we are discussing for care because our patients have limitations that are unique. They have limited funds for food, vitamins for surgery, exercise options that are safe in their neighborhoods, and limited insurance coverage for weight loss medications.

3. History of Metabolic Bariatric Surgery (MBS) and Obesity Medicine Designation (OMD)

3.1. Dr. Frederiksen

Thank you for your introductions. By way of background, in addition to my roles at the OMA, I am board-certified in Internal Medicine and Obesity Medicine and have been practicing clinical medicine for 25 years. I have had the opportunity to build and lead several large-scale obesity medicine programs, including two practices within Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP)-accredited metabolic bariatric surgery centers. I have also served as a director for a national, all-virtual obesity medicine practice, and currently am the Medical Director for the Bariatric Center at Mayo Clinic Florida. It is a comprehensive program that combines obesity medicine, endocrinology as it relates to obesity, endo-bariatrics, and metabolic bariatric surgery. We are fully accredited with the Obesity Medicine Director designation, and our endo-bariatric procedure pathways are also included under that accreditation.

I believe that this kind of comprehensive approach should be the norm. Right now in the U.S., though, obesity medicine, endocrinology as it pertains to obesity care, and metabolic endoscopic or surgical practices often operate in separate silos. Referral patterns and standards of care vary widely depending on the setting. As of 2024, there are more than 900 MBSAQIP-accredited centers of excellence (COE) in the U.S. and Canada [7]. These centers carry different levels of accreditation, and there is no consistent model for how care is delivered. Similarly, obesity medicine practices do not have a center of excellence designation and vary widely in scope and standards. In our center, which is an academic-based private medical system, we have the benefit of significant support for the comprehensive accredited COE clinical practice, including direct access to the highest quality specialty network for referrals and related care, and cutting-edge research and data to guide our work. Many patients, however, still have limited means with which to access the comprehensive treatments that we offer.

Before we dive into the details of those different models, we can start with a broader look: the role of both the obesity medicine specialist and the bariatric proceduralist or surgeon, the main treatment options available for people living with obesity, from prescribed lifestyle changes to medications and procedural interventions, and what outcomes can be expected from each approach.

Dr. Berger and Dr. Mattar, can you give us a brief history of certification in obesity medicine and in bariatric surgery, respectively?

3.2. Dr. Berger

Obesity medicine officially became a recognized specialty in 2013 with the introduction of board certification. But even before that, many healthcare providers were already practicing in this field, some certified through the American Board of Bariatric Medicine (ABBM), which came before today's certifying body the American Board of Obesity Medicine (ABOM). Founded in 2011, the ABOM set standards for evaluating and credentialing doctors in the specialty. Earning ABOM certification shows that a physician has advanced knowledge and skills in treating obesity and it highlights their commitment to providing expert care. In practice, obesity medicine providers take a science-based, personalized approach to treatment, tailoring care to each patient to improve their overall health and outcomes.

3.3. Dr. Mattar

The first metabolic surgery dates back to 1954, when surgeons performed a jejuno-ileal bypass to treat severe dyslipidemia [8]. While it did address the intended metabolic issue, it came with serious side effects such as significant malabsorption and liver injury. Over the following decade, surgeons made a series of adjustments to improve the procedure's safety and viability. In 1966, an interesting observation changed the field: patients who had undergone a sub-total gastrectomy for cancer were noted to lose a significant amount of weight beyond that expected from the malignancy alone. That insight led to the first true "bariatric surgery," the gastric bypass [9].

Fast forward to the mid-2000s—recognizing the need for consistent standards—the American College of Surgeons (ACS) and the American Society for Metabolic and Bariatric Surgery (ASMBS) rolled out accreditation programs for bariatric surgery centers between 2004 and 2006. The ASMBS launched its Bariatric Surgery Center of Excellence (BSCOE) program in 2004, and by 2006, the Centers for Medicare &

Medicaid Services (CMS) required that facilities be certified.

3.4. Dr. Frederiksen

Thank you both. I think we would all agree that anyone who meets the criteria for overweight/pre-obesity or obesity qualifies for, and should be offered, an evidence-based prescription for lifestyle intervention, which is the foundation of any obesity treatment plan. That said, lifestyle changes alone usually lead to only modest weight loss and can be hard to maintain over time, typically achieving under 10% weight loss and weight regain of 50% or more is common [10,11]. The landmark intensive lifestyle intervention trial Look AHEAD, which studied weight loss in those with overweight and obesity and type 2 diabetes, showed 8.6% weight loss at one year and 6% weight loss by study end which was 13.5 years. Weight loss in this range did not reduce the rate of cardiovascular events in study participants [12]. Follow up studies have shown similar findings, although outcomes closer to 10% weight loss can be achieved with targeted and more individualized therapy [13–15]. In a meta-analysis of 29 long-term weight loss studies, more than half of the lost weight was regained within 2 years, and more than 80% of the lost weight was regained by 5 years [16].

This is why more intensive interventions are so important for improving outcomes. Strategies such as pharmacotherapy—often managed by obesity medicine specialists—and procedures like bariatric surgery or newer, non-surgical endoscopic options, have been shown to produce more substantial and sustained weight loss, improve metabolic health, and reduce morbidity and mortality in people with obesity (Fig. 1a). Considering these as a continuum of obesity care, with different therapeutic options, is highlighted here (Fig. 1b), and we will be looking at some of the supporting data today.

4. Pharmacotherapy for the treatment of obesity

4.1. Dr. Frederiksen

Turning to pharmacotherapy for the treatment of obesity, Dr. Shetye, can you give us an overview of the pharmacological treatment of obesity?

4.2. Dr. Shetye

Pharmacotherapy for the treatment of obesity has been an option since phentermine was approved for short term use in 1959. Several obesity medications (OM) are approved for long term use, including phentermine with topiramate under the brand name Qsymia, bupropion and naltrexone as combined under the brand name Contrave, and liraglutide, under the trade name Saxenda. Criteria for those who qualify include those with a BMI of 27 or higher and complications from pre-obesity or a BMI of 30. These medications typically provide weight loss approximating 10% when prescribed in combination with intensive lifestyle modification [17–19].

The last five years, however, have been a game-changer. Newer medications (glucagon-like peptide-1 or GLP-1 agonists) have dramatically shifted what we can expect from pharmacotherapy—not just in terms of weight loss, but also in improving metabolic health. Semaglutide, approved by the Food and Drug Administration (FDA) in 2021 for obesity under the brand name Wegovy, produces an average weight loss of about 15%. Tirzepatide, approved in 2023 as Zepbound, goes even further, with average weight loss approaching 21% [20,21].

Beyond weight loss, these medications have significant health benefits, reducing cardiovascular risk and improving metabolic dysfunction–associated steatohepatitis, heart failure with preserved ejection

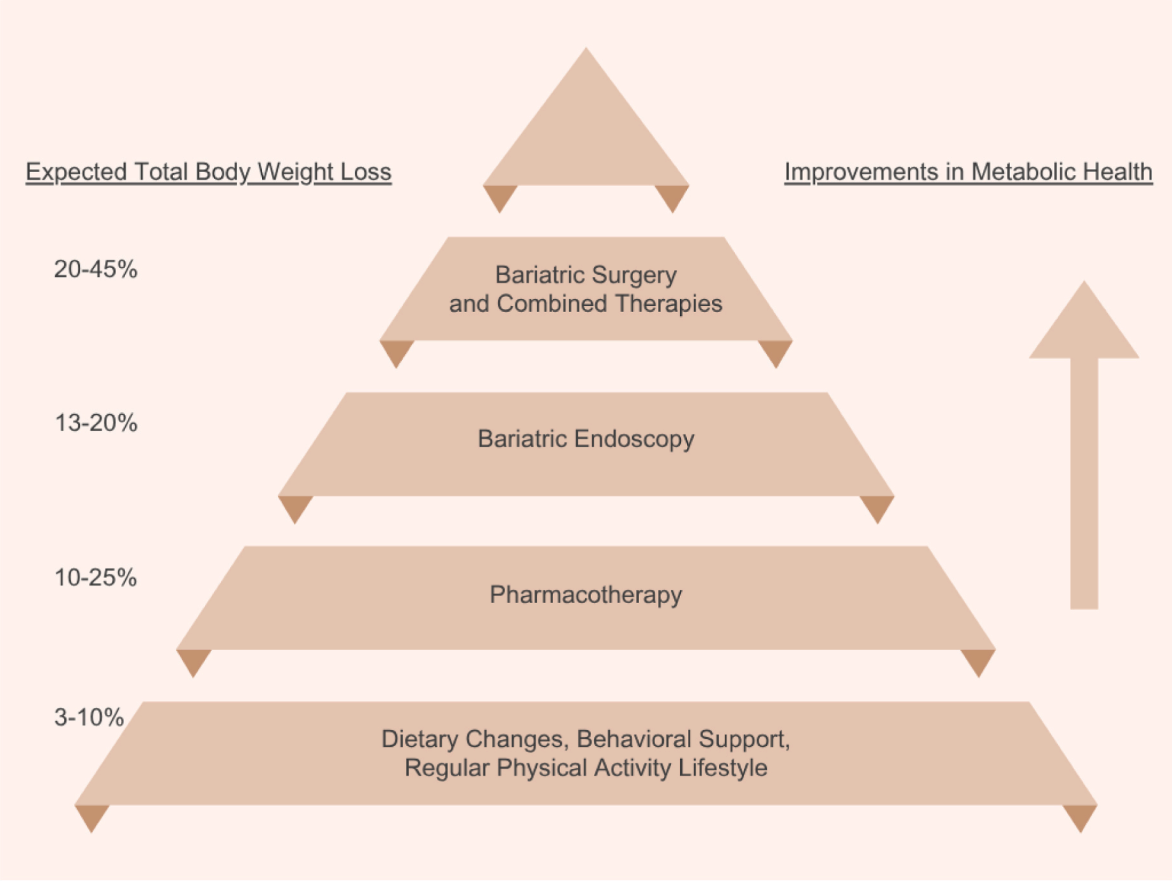

Fig. 1a. Therapeutic options for obesity care.

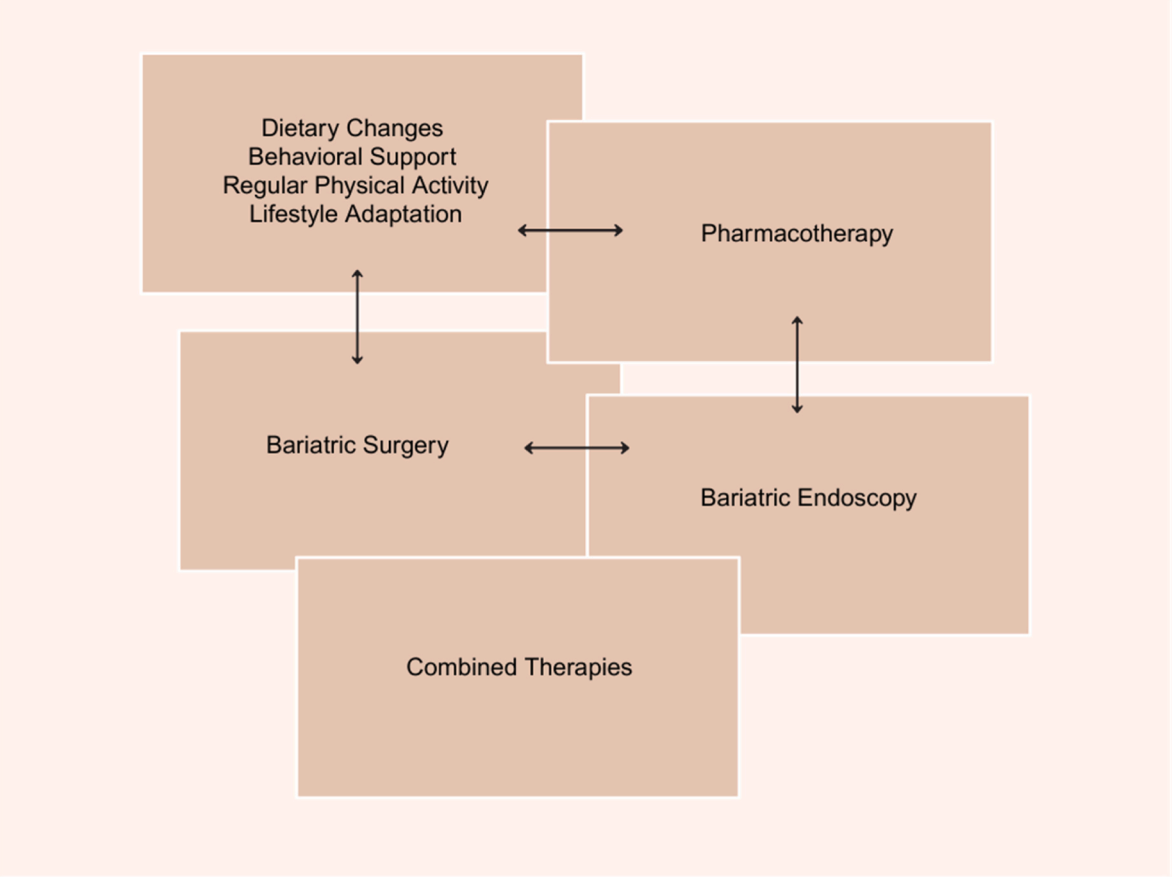

Fig. 1b. Therapeutic options for obesity as a continuum.

fraction and obstructive sleep apnea [22–24]. The list of potential indications continues to grow. They are generally well tolerated, with mild to moderate gastrointestinal symptoms such as nausea or constipation being the most common side effects.

It is important to note that if these medications are stopped, weight regain can recur and metabolic outcomes worsen again [25]. In other instances, weight stabilization occurs and metabolic outcomes are much improved. An estimated 12% of U.S. adults have tried one of the newer GLP-1 medications, yet recent data show that only 35% of those starting the highly effective OMs continue them 1 year after initiating the therapy [26]. Ideally, they are used as part of a comprehensive care program that provides full patient support—not just prescriptions. Since obesity is a chronic disease, ongoing medication management is essential, both during weight loss and for long-term weight maintenance.

5. Metabolic bariatric Surgery for the treatment of obesity

5.1. Dr. Frederiksen

Dr. Mattar, can you give us a high-level overview of metabolic bariatric surgery for the treatment of obesity?

5.2. Dr. Mattar

Metabolic bariatric surgery has substantial evidence to show it is the most effective therapy for the treatment of severe obesity. Traditionally, it was offered to people with a BMI of 40 or higher, or 35 with obesity-related health problems. Newer guidelines have lowered the threshold to a BMI 30 with associated diseases or 35 without associated diseases [27].

Surgery works not just by reducing stomach size, but also by changing gut hormones, metabolism, and nutrient flow [28]. On average, patients lose around 26% of their body weight after sleeve gastrectomy and 28% after gastric bypass within 1–2 years, and much of this weight loss is sustained long term [28–30]. With that weight loss, body composition improves. A study of body composition showed both fat free mass and skeletal muscle mass higher in surgical patients at one year than in non-operative matched controls, along with a significant reduction in the metabolically-active truncal fat mass [31].

Beyond weight loss, surgery often resolves conditions like sleep apnea, high blood pressure, and type 2 diabetes, just to name a few, in over half of patients. Gastric bypass, for example, is linked to lower rates of heart disease, cancer, and overall mortality. While risks exist, serious complications are rare (<1 %), and the 30-day mortality rate is about the same as childbirth [32–35]. Outcomes from RYGB show a decrease in all-cause mortality of 40%, decrease in coronary artery disease of 56%, a decrease in overall cancer rates of 60% and improvement in health-related quality of life measures [29,36–40].

Weight gain recurrence happens for some, but most patients maintain long-term benefits. Weight gain recurrence ranges from 11.2 to 45.9%, depending on the definition used and criteria for nadir weight [41,42]. However, most patients maintain a healthy weight post-operatively, with some studies indicating that at 15 years post-RYGB surgery, 70% of patients maintain at least 20% body weight loss [43]. Compared to newer weight-loss drugs, surgery delivers about five times more weight loss [44].

Importantly, national accreditation programs have helped make surgery safer than ever. The MBSAQIP program was created to address the variability of clinical outcomes that had been present prior to accreditation. Accreditation, standardization and oversight have been the major drivers of one of the most celebrated safety accomplishments in modern surgical obesity care.

6. Endo bariatrics for the treatment of obesity

6.1. Dr. Frederiksen

Dr. Jad, can you give us an overview of the newer minimally invasive endoscopic bariatric procedures for the treatment of obesity? Given that you are a bariatric surgeon, how do you see the intersection of endo-bariatrics and surgical bariatric procedures for collaborative care?

6.2. Dr. Jad

Newer, more minimally invasive, non-surgical interventions including endoscopic sleeve gastroplasty (ESG), a potentially reversible endoluminal procedure using full thickness sutures to reduce the stomach size into a sleeve-shape, have become available in recent years since FDA approval in 2022, showing benefit with mean percentage total body weight loss of 13.6% at 12 months and sustained weight loss in 68% over 2 years [45]. This procedure is indicated primarily for Class 1 and Class 2 obesity and is typically less effective for those with a BMI over 40 or for those with severe, complex obesity. Improvements in type 2 diabetes and in hypertriglyceridemia control have been noted after the ESG procedure, but not changes in ghrelin, hormone PYY or GLP1 levels, as occur after SG [46].

While weight loss is less than with SG, serious adverse events are low (2%) since the stomach is preserved [47]. ESG will not replace metabolic bariatric surgery, but it is a good option for lower BMI patients who cannot undergo MBS or prefer to pair a procedure with medication [48]. Because stomach preservation limits hormonal changes, weight regain can be more common, so studies are exploring whether adding obesity medications 3–6 months post-ESG procedure improves long-term outcomes. Insurance coverage for the ESG is expected in 2026.

Collaboration between endobariatric and surgical teams is especially valuable for weight gain recurrence (WGR). For example, patients with WGR following RYGB may benefit from transoral outlet reduction (TORe), which narrows the opening between the stomach pouch and bypassed intestine to slow gastric emptying and improve satiety. TORe has become an important option for patients who are not candidates for revision surgery or may not tolerate obesity medications. Promising data are emerging regarding total body weight loss post TORe [49].

7. OM and MBS collaborative practice models

7.1. Dr. Frederiksen

With that background in mind, let us look at the main ways obesity care can be structured when combining lifestyle intervention, pharmacotherapy, and bariatric procedures—and talk about the pros and cons of each. I am especially interested to hear from our panelists which models they have found most effective and why. One of the reasons we are having this discussion is to address why a more fully integrated model of care for the treatment of obesity is of value. There are multiple reasons this approach can be advantageous. I will not speak for each of the panelists, but I think in general we all have experienced and support the idea that more collaboration and integration of obesity care leads to better outcomes and patient satisfaction, especially given the multifactorial nature of this disease.

Broadly, there are three main models:

a. **Independent OM and MBS practices** (Fig. 2) - These operate separately, with their own care pathways, resources, and leadership.

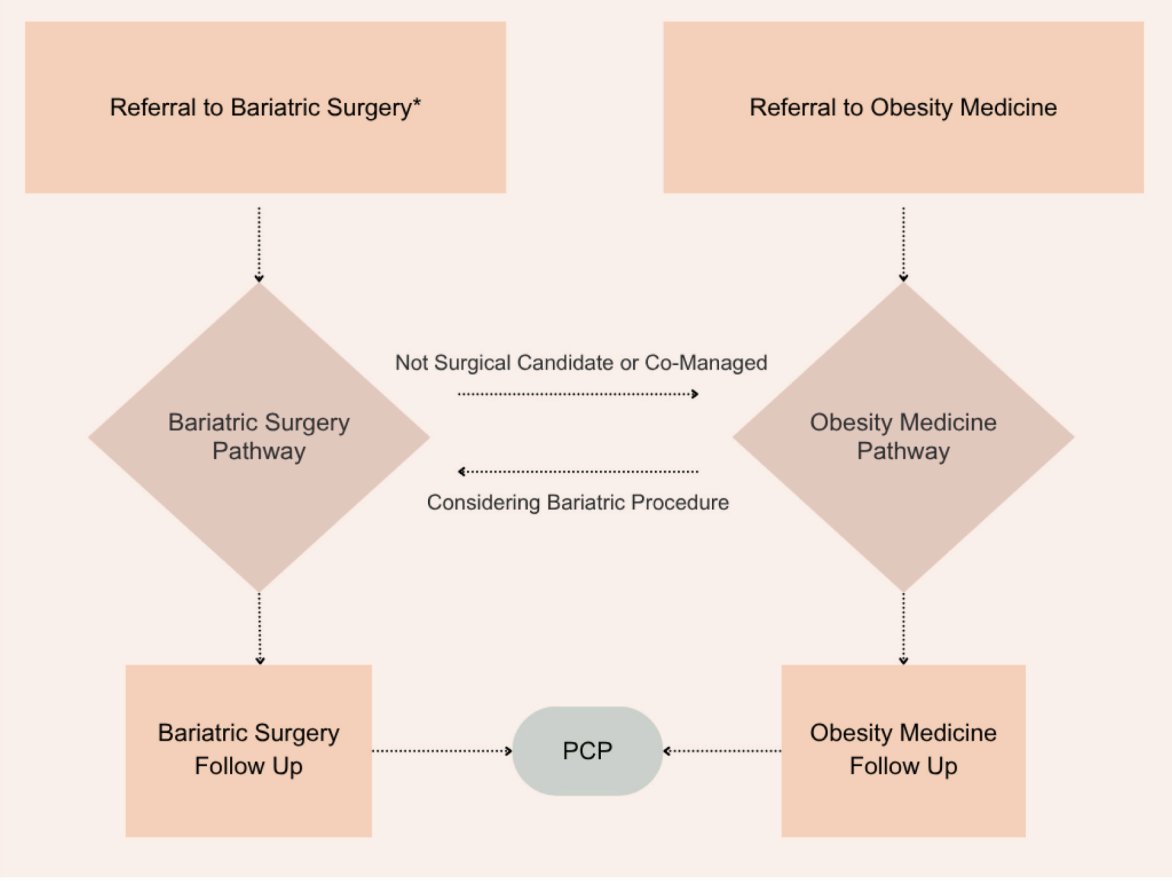

Fig. 2. Independent Obesity Medicine and Metabolic Bariatric Surgery Practice Model.
(Bariatric Surgery* here may include endo-bariatrics and procedures; PCP = Primary Care Provider).

Patients may enter through either practice, and while there can be some collaboration, it is not the default. The upside is autonomy; the downside is potentially fragmented referrals and duplicated resources. Separate OM and MBS practices have documented this, with low rates of referral to bariatric surgery even in a large health system where obesity medicine/endocrinology/weight loss and metabolic surgery co-existed but were not combined in one program [50].

b. **Separate OM and MBS care/combined program** (Fig. 3) - These are essentially different practices under the same care umbrella and typically share space and resources. The entry point is either via OM or MBS directly, or via a bariatric-focused, therapeutic endoscopy practice so either may manage the patient at any point in time. A hub and spoke model works well with this arrangement, whereby the hub treats advanced medical and bariatric surgical patients in one practice site, even if patients enter via OM or MBS. The spokes treat less advanced disease, such as in a primary care-focused setting, and refer to the hub practice as needed. Benefits include improving access to both obesity medications and MBS [51]. Some referral obstacles remain, as initial referrals may be complex and not clearly directed to OM or MBS by a referring provider. With this model, there is potential for duplicating resources. The ASMBS-OMD qualification can be pursued in this practice model.

c. **Shared OM and MBS care/combined program** (Fig. 4) - This is the most integrated model, with a single-entry point—usually intake is via obesity medicine—and one coordinated care pathway. The whole team usually works in one location, and patients can move seamlessly between surgical and non-surgical care. It maximizes access to all treatment options and often supports stronger advocacy and training programs. The main trade-off is a potential slight delay in surgical referrals if OM sees all patients first, though that is less of an issue with strong integration. The ASMBS-OMD qualification can also be pursued with this model. Given the complex needs of patients with severe obesity, this practice model often allows the greatest access to all therapeutic modalities, including medical, bariatric endoscopic and surgical, that such patients may need over the course of their care journey. It also allows ready access to integrated health resources such as dietitians and mental health specialists who are typically more available in these models, since overhead costs are shared by more practitioners.

Dr. Berger, can you describe your experience with these models, how you have collaborated across the aisle, so to speak, and the pros and cons of different practice models from that experience?

7.2. *Dr. Berger*

Although published data comparing outcomes across the various practice models is not abundant, data have shown a multidisciplinary combined approach to treatment leads to significant patient success [52]. Some of the reasons, in my experience, are:

a. **Obesity is complex and requires a comprehensive, long-term strategy.** Obesity is a chronic, progressive condition that usually cannot be effectively managed with a single treatment approach. A multidisciplinary model allows us to combine tools, like surgery and medications, for better overall results [53]. For example, at least 30% of patients experience weight regain after bariatric surgery and those on obesity medications may regain up to two-thirds of their weight

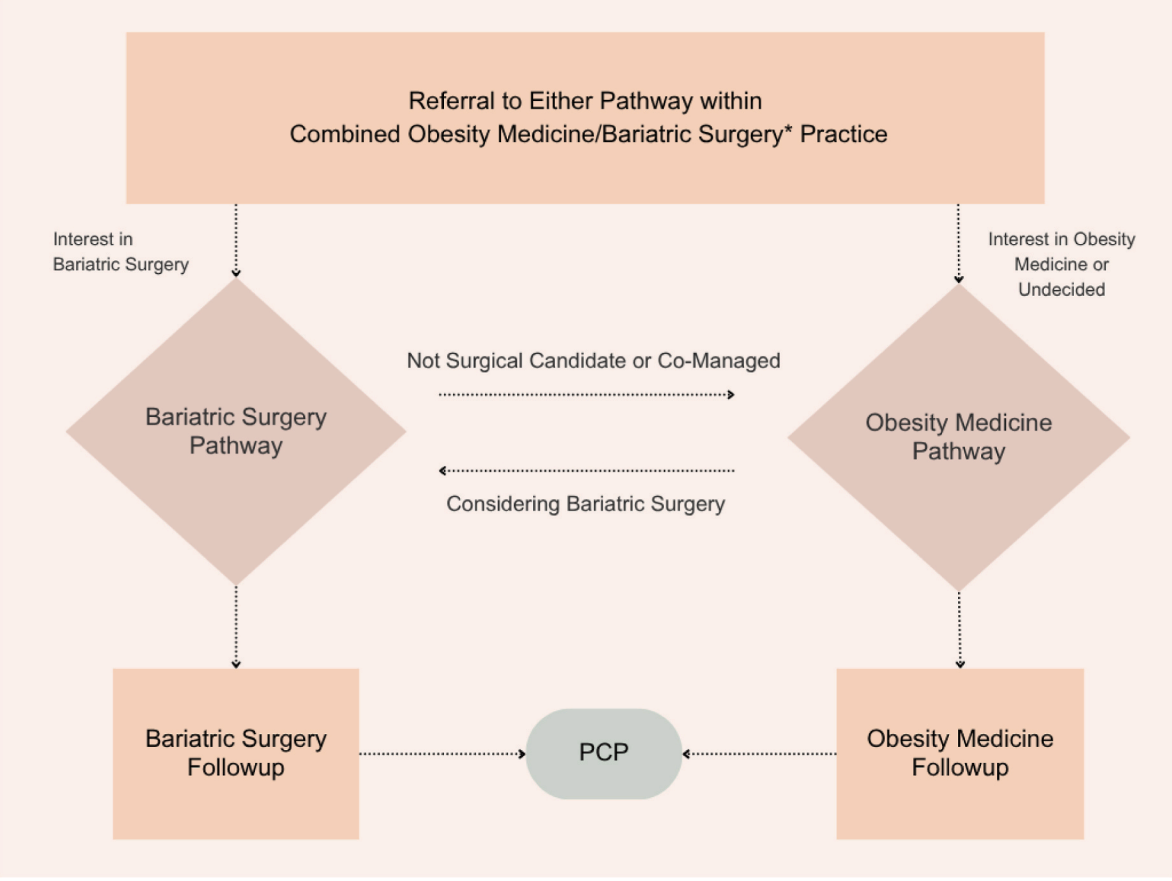

Fig. 3. Separate Obesity Medicine and Metabolic Bariatric Surgery Care/Combined Program Model. (Bariatric Surgery* here may include endo-bariatrics and procedures; PCP = Primary Care Provider).

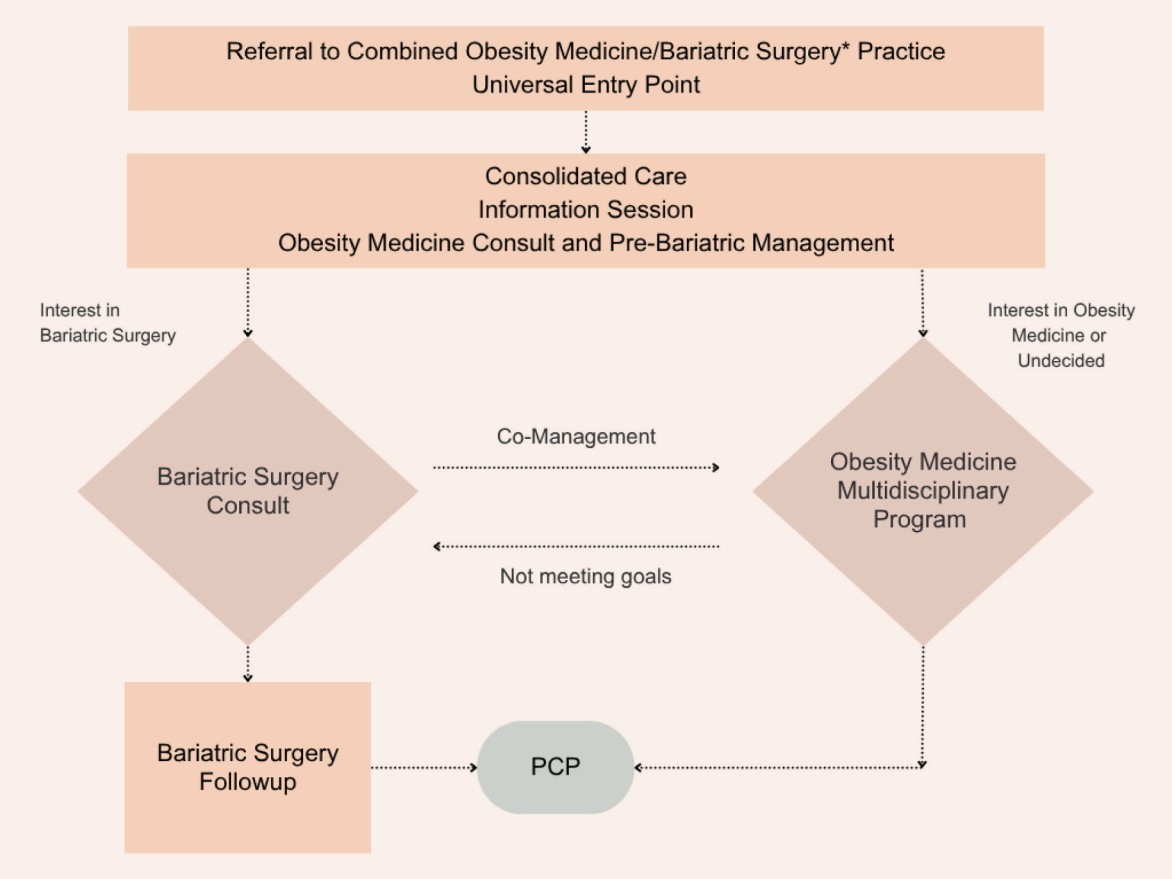

Fig. 4. Shared Obesity Medicine and Metabolic Bariatric Surgery Care/Combined Program Model. (Bariatric Surgery* here may include endo-bariatrics and procedures; PCP = Primary Care Provider).

loss within a year after stopping pharmacotherapy [54,55]. That is why many patients may benefit from both treatment types over the course of their lives. Patients who qualify for both obesity medication and bariatric surgery need to be fully informed of all available options. Navigating this kind of care often requires an understanding of specific insurance requirements, which integrated, specialty-based practices are typically better equipped to handle.

b. **Obesity medicine brings critical support and personalization.** Obesity medicine provides a more holistic view of the patient. It helps address contributing factors like behavioral health issues, low physical activity, and social or emotional challenges. It also supports pre- and post-operative care, helps manage weight regain, and fosters better, more informed decision making between patients and providers. This kind of ongoing, tailored support is a major advantage of the integrated model.
c. **The gap between outcomes from obesity medications and surgery is narrowing.** While MBS remains the most effective treatment for obesity and related complications, some of the newer OMs are starting to deliver comparable outcomes, especially in terms of weight loss and overall health improvement. They also offer added benefits, like cardiovascular and renal protection, and improve conditions like metabolic associated liver disease and obstructive sleep apnea [22,24,56–58]. Looking ahead, endo-bariatric procedures may further bridge the gap for patients who either are not ready for surgery or have not had success with obesity medications. These options can give more flexibility in tailoring care to each patient's needs and preferences.

Healthcare is moving toward a more team-based approach – especially in obesity care. In the U.S., MBSAQIP accreditation for bariatric surgery centers now encourages centers to include obesity medicine services alongside surgery. Starting in 2019, a special "Obesity Medicine Qualification" was added to its standards – available only to Comprehensive Centers of Excellence (COE). These centers bring together a full care team, including dietitians, psychologists, exercise experts, and more – led by an Obesity Medicine Director working closely with the surgical team. Available also are modes of measuring and following body composition regularly, including scales that measure fat mass and lean muscle mass, for example, important health parameters that change for better or worse during the course of treating obesity and can guide appropriate therapy. In more recent years, with the advent of non-surgical, endoscopic bariatric procedures, gastroenterologists specializing in bariatric procedures may provide care under the COE umbrella, thus expanding the scope of care and making such programs more truly comprehensive in nature. Despite this progress, the integrated model is still rare. Only a small fraction of the roughly 1000 accredited centers have the obesity medicine add-on. The result is that the majority of patients continue to experience fragmented care, where medical patients may never be referred for surgery even when indicated, and surgical patients may not get ongoing medical follow-up when needed (Table 1).

With regard to qualifying obesity medicine providers in a COE, the current standards require obesity medicine certification, typically via the American Board of Obesity Medicine. This may limit some centers from seeking COE qualification that would otherwise meet the criteria, as these centers may be run by providers with many years of experience in treating this disease - with excellent outcomes - but do not carry ABOM certification. This is in contrast to some carrying the ABOM certification - who may be newly minted with regard to having passed the ABOM certification - but have very limited experience in the care and treatment of those with obesity and may have only taken continuing

Table 1
Obesity Medicine and Metabolic Bariatric Surgery Collaborative Practice Models: Benefits and Drawbacks
(OM=Obesity Medicine; MBS = Metabolic Bariatric Surgery; ASMBS-OMD=American Society for Metabolic and Bariatric Surgery Obesity Medicine Designation; OMs = obesity medications).

Clinician	• Limited education, experience in and exposure to obesity as a disease and its care • Misinformation about obesity care • Stigma, bias • Doubts about safety and efficacy of obesity pharmacotherapy and/or interventional approaches to obesity care • Attitudes towards obesity and treatment of the patient with obesity • Attitudes towards referrals for specialty care in obesity • Lack of adherence to standards of care • Limited time to address the disease
Systemic	• Complexity in the referral process • Lack of standard treatment guidelines and coding • Lack of appropriate reimbursement • Lack of adequate insurance coverage for pharmacotherapy and/or interventional approaches to obesity care • Lack of availability of care • Entrenched stigma and bias
Patient	• Limited education, experience in and exposure to obesity care • Misinformation about obesity care • Stigma, bias, self-doubt, fear • Doubts about safety and efficacy of obesity pharmacotherapy and/or interventional approaches to obesity care • Influence of food culture, social media • Lack of access to care
Environmental, Cultural	• Unhealthy food culture • Unhealthy nutrition options • Food deserts • Heavy influence of misinformation from socal media, public and some in medical community • Influence of cultural norms and bias that may be counterproductive for healthy living • Persistent stigma surrounding the disease of obesity

education credits as part of their certification. I believe this issue will be addressed by certifying boards in the near future, so it will be interesting to see how they move forward on this question.

8. Benefits and disadvantages of integrated OM & MBS care

8.1. Dr. Frederiksen

Dr. Mattar, what is your experience with these different models of care, and what do you feel are the benefits or downsides of more fully integrated, comprehensive programs versus separation of care into either obesity medicine or bariatric surgery practices?

8.2. Dr. Mattar

This past spring, ASMBS hosted its first-ever Obesity Summit, bringing together about 100 leaders—from clinicians to industry and patient advocates—with the goal of focusing on what truly benefits patients. There was consensus that obesity care suffers when it is fragmented and they therefore agreed to launch a long-term initiative to fix this by improving coordination. Although no specific care models have been finalized, the group emphasized that obesity treatment could yield better results when delivered through coordinated, multidisciplinary evaluation, similar to that in oncology or transplant programs.

They identified four main types of barriers (Table 2):

- Clinician-level issues—such as low referral rates, lack of training, and clinician stigma
- Systemic challenges
- Patient-related obstacles
- Environmental and cultural hurdles

For example, fewer than 10% of people who qualify for bariatric surgery are actually referred—and only about 1% receive surgery—often due to provider hesitation or misinformation [59,60]. Surveys show nearly half of primary care doctors feel they need more education about bariatric surgery. These gaps are not just clinical, they also impact access and outcomes [50,59–65]. Some studies show patients are more likely to initiate the request for referral to bariatric surgery, not their

Table 2
Real and perceived barriers to referrals for obesity care.

Practice Model	Independent Obesity Medicine and Metabolic Bariatric Surgery Practices	Separate Patient Care/Combined Practice	Shared Patient Care/Combined Practice
Patient movement through program	• Different practices • Different pathways	• Single practice • Different pathways	• Single practice • Single pathway
Oversight of patient care	OM or MBS manages patient at any given time	OM or MBS manages patient at any given time	OM manages all or most patients at any given time
Economies of scale	• No shared resources • No economies of scale	Shared resources of some space and staff	Shared resources of most or all space and staff
Referral process	Dual entry points, bidirectional flow between OM and MBS	Dual entry points, bidirectional flow between OM and MBS or two distinct pathways	Singular entry point
Potential benefits	• Autonomy • Easier access to either OM or MBS • Easier referral pathway for patients only interested in OM or MBS	• Entire practice team in one or several locales • Consistent messaging • Easier transition of patients between OM and MBS, based on need and preferences • May improve access to OMs for MBS patients, referral to MBS • Practice can pursue ASMBS-OMD qualification • Improved advocacy by combining forces • Improved opportunities for obesity-focused training programs	• Entire practice team in one locale • Consistent messaging • Easiest transition of patients between OM and MBS, based on need and preferences • Least delay in access to OMs and MBS referrals • Practice can pursue ASMBS-OMD qualification • Improved advocacy by combining forces • Improved opportunities for obesity-focused training programs
Potential drawbacks	• No economies of scale for resource sharing • Most barriers for comprehensive care • Messaging may be inconsistent • Separate and delayed referrals to OM or MBS • OM cannot pursue ASMBS-OMD qualification	• Potential for duplication of resources utilized • Hub and spoke model can delay care and be inconvenient for patients • Potentials for overlap in leadership, programming, budgets	• Required start with OM may reduce MBS volume • Less flexibility to add new OM services if focus more on MBS care

providers [66,67].

The COE designation for Additional Obesity Medicine Qualification remains in development and evolution. Its main criteria are that there be a Medical Director for the Obesity Medicine arm of a Comprehensive Metabolic and Weight Loss Program. The other criterion is that there be a dedicated database (not necessarily a proprietary database) that tracks the progress of all patients receiving obesity medicine (non-surgical) management. In our discussion here, we did not make any assumptions that carrying the OM COE designation was linked to quality outcomes or that in rendered clinical superiority. It is still premature to make conclusions regarding the association of OM COEs with quality of care, as this initiative is still at an early stage of development, and there are, at the present time, insufficient numbers of COEs to allow for meaningful comparisons or conclusions.

9. Opportunities for improving OM & MBS collaborative care

9.1. Dr. Frederiksen

Dr. Jad, based on your experience and some of the challenges discussed by Drs. Berger and Mattar, what would you see as opportunities for facilitating more collaborative care? What are some insights from your experience outside the U.S. that could provide opportunities for improving the U.S. model?

9.2. Dr. Jad

Interestingly, referral patterns for obesity care and metabolic bariatric surgery (MBS) in Canada mirror those in the U.S., despite a very different health system. In Canada, primary care providers are the gatekeepers, yet referral rates remain under 1%—about 1 in 171 eligible adults each year [59].

From a clinical perspective, solutions include reframing how we talk about obesity—as a treatable disease like any other—building trust with patients, improving provider education, and creating avenues for collaborative case discussions. A major barrier remains the misconception that bariatric surgery is unsafe. Educating both primary care providers and patients on its proven safety—comparable to other common procedures—can help. This can be done through targeted initiatives like symposiums, conference presentations, and publishing safety data.

On a systems level, we can advocate for more public-private partnerships in prevention, reduce insurance denials for surgery, medications, and counseling, standardize treatment guidelines and coding, promote workplace wellness, and address social determinants of health. The work of this roundtable shows how collaboration across specialties can make these goals a reality [68].

10. Impact of obesity pharmacotherapy on collaborative obesity care

10.1. Dr. Frederiksen

Dr. Shetye, patient preference is now typically trying obesity medication first, even for those with severe obesity. Across the U.S., new bariatric surgery cases are down by 26% or more in some areas, partly due to preference for obesity medication over a bariatric procedure [69]. Speak to the role of these medications, especially for those with severe, complex obesity, in this shift and how you see the collaborative care model in this context.

10.2. Dr. Shetye

Let's be honest—there has long been an unnecessary bias against bariatric surgery, even before GLP-1 medications became widespread. Shockingly, as was previously mentioned, only about 1% of the roughly 20% of patients who qualify actually undergo bariatric surgery [59,70]. One reason is that many healthcare providers simply are not well-informed about obesity treatment. Social media has not helped, either—it can spread misleading messages. Meanwhile, drugs like semaglutide and tirzepatide have made a splash with solid weight loss—great for mild-to-moderate obesity, but not always enough for more severe obesity [71]. Plus, access to treatment can be patchy, meaning some patients who really need surgery experience delays in their care [72].

Another issue is how the boom in virtual obesity care and weight-loss medications has sparked overprescribing—sometimes with more readily available yet poorly regulated compounded formulas that harm patients. Practices driven by volume and quick scripts often under-refer patients for surgical or endoscopic options, which is often more appropriate for those with severe obesity.

Tellingly, surgery volumes began to dip already in 2020 and 2021—partly because of the pandemic, but possibly also due to a reduction in referrals, cost, availability of more highly effective obesity medications, and education gaps within the referring provider community [73]. In short, the least effective treatment options often get the most support, while surgery—the most effective—still gets underutilized. Perpetuating the problem, many insurers require patients to continue to making lifestyle changes alone, when we know this usually results in just 5–10% weight loss. Then, even if medications are approved, it is often the older ones which only offer modest results. All of this leaves those with severe obesity underserved. An integrated care model could help redirect some of those patients toward more intensive medical treatment while keeping surgical candidates moving closer to bariatric surgery—so no one falls through the cracks.

11. Barriers and cost-effective approaches for comprehensive obesity care

11.1. Dr. Frederiksen

Dr. Berger, would you like to expand on that? Can you speak to the role of insurance and barriers to obesity care, in particular to those who need a collaborative approach for more severe disease?

11.2. Dr. Berger

I completely agree. Access is one of the biggest barriers to effective obesity care today. Many of the requirements we see, that are mandated by insurance, are not always evidence-based or cost-effective, especially when it comes to treating obesity.

Take step therapy, for example, as was mentioned. Often, insurance companies dictate that patients have to go through a set sequence of treatments before getting access to more advanced options. But, again, we know that for people with severe obesity, the most successful treatments are more intensive and need to be personalized. Requiring every patient to follow the same rigid path—without clear evidence it works for everyone—can actually delay effective treatment and potentially cause harm and progression of their comorbid diseases. Even worse, this kind of approach might save money for insurance companies or employers in the short term, but it is not necessarily cost-effective for anyone in the long run.

Another issue is limits on coverage of therapy. Once a patient hits their maximum allowable coverage, they may lose access to a medication that was actually working for them. And when that happens, weight regain is common. This idea of "deprescribing" without a long-term plan for supporting appropriate treatment just is not effective, is not supported by evidence, and does not serve patients or payers well down the road. We are also seeing limited coverage for bariatric procedures, and more patients being pushed into fully virtual care models, sometimes even being denied in-person care altogether.

But here is the good news: we are finally starting to see solid data showing that more intensive treatments can be cost-effective when used

appropriately. A 2025 report by the large employer group AON found that patients using GLP-1 medications had a 44% lower risk of hospitalizations due to cardiovascular events over a two-year period. And for employers, the financial benefit was clear too, showing that cost growth diverged by 50% between those receiving GLP-1 treatment and a control group, within just 12 months.

We are also seeing promising results from procedures like endoscopic sleeve gastroplasty, which has been shown to be more cost-effective than GLP-1 use in some cases, offering better sustained weight loss over five years [74]. And when we look at people with severe obesity and type 2 diabetes, studies comparing different treatments, including medical therapy, sleeve gastrectomy, and Roux-en-Y gastric bypass, actually found gastric bypass to be the most cost-effective option over a five-year period. That is important, especially for a population that often struggles to access appropriate care [75].

So, taking all of this into account, I think it is crucial that we do not lose sight of the value of comprehensive obesity treatment programs. These programs are not just for those with mild disease, they can provide a continuum of care across the spectrum of obesity, meeting patients where they are at every stage of their journey. Ultimately, what we should be striving for is a system that offers patients access to personalized, evidence-based care throughout their lifetime. Whether that is in the form of a differentiated medical home or a trusted referral center, the goal should be consistent: better outcomes, better quality of life, and smarter long-term investment in health.

12. Creating a combined OM-MBS program

12.1. Dr. Frederiksen

We have spoken about the reasons for and evidence to support a more comprehensive approach to obesity care and how combining obesity medicine and endoscopic bariatric and/or metabolic bariatric can be an important step towards improving patient outcomes. We have discussed what such collaborative care looks like, what some of the barriers to this model are and some effective ways to reduce these barriers and improve access to care.

Dr. Shetye, what would you say creates a successful comprehensive approach?

12.2. Dr. Shetye

When combining obesity medicine and bariatric practices, several key points are:

- **Institutional buy-in and collaborative planning** with all stakeholders
- **Creating and following guiding principles** that include communication, quality measures, goal setting, and ongoing review and improvement
- **Optimizing referral pathways** into the practice, with a streamlined process, regular bi-directional communication, clear referral criteria, and regular adjustments to the process
- **Finding opportunities for referring provider education**, given ongoing negative perceptions and concerns about obesity care and in particular as it centers on bariatric procedures

12.3. Dr. Frederiksen

Dr. Mattar, what should be considered for implementation of a combined OM-MBS program?

12.4. Dr. Mattar

The decision-making process around implementation needs to take into consideration both specialties' goals in patient care, limitations of budget, space and staff, as well as the needs of the larger organization. Most important would be:

- **Starting the conversation**, including reasons for combining programs, potential barriers, opportunities and identifying key stakeholders, as well as motivation of various decision makers and their understanding of obesity medicine and bariatric practice
- **Determining goals and objectives** of a combined program, such as economies of scale, increased patient volume, improved outcomes, revenue generation
- **Establishing program needs and design**, such as the visit model, an organizational chart, protocols, and staff education
- **Defining measures of success**, such as quality metrics and resource value units (RVU) models
- **For ASMBS-OMD Centers of Excellence**, an Obesity Medicine Director (OMD) becomes part of the MBS team, and standardized protocols, training, and data collection are incorporated

12.5. Dr. Frederiksen

Dr. Jad, as far as the business aspects of the combined practice, what would you recommend as key components?

12.6. Dr. Jad

- **Start with a business plan** – it is the foundation for any newly combined practice
- **Lean into your business and admin teams** – they can help with insurance contracts, ROI planning, tracking overhead/expenses, and mapping out revenue opportunities (both in the practice and downstream to the health system)
- **Identify your needs early** – facilities, equipment, and staffing
- **Be Market Smart** – reach out to referring providers, connect directly with patients, and build partnerships with local businesses and employers
- **Track your progress** – set up systems for data collection and ongoing analysis in both obesity medicine and bariatric surgery
- **Empower your champions** – find passionate leaders (a surgeon, dietitian, physician) and give them targeted resources to drive growth and engagement. In my Canadian clinic, this approach helped the program expand efficiently and effectively.

13. Lessons learned for integrating obesity medicine and bariatrics for comprehensive obesity care and future opportunities

13.1. Dr. Frederiksen

Dr. Berger, what are lessons you have learned from successfully combining obesity medicine and bariatric surgery into a more integrated practice?

13.2. Dr. Berger

I would consider 4 points to be really important in this regard:

- **Start with a clear program structure.** That means outlining the care pathways, how referrals are handled, who does what in the organization, how long patients will be involved, and what the care goals are. It is also important to clarify the role of the obesity medicine provider in the context of metabolic and bariatric surgery, make sure the team has the resources they need, and set some clear benchmarks for outcomes.
- **Adopt a growth mindset.** Stay open to learning and improving as the program evolves. It is all about being flexible and willing to adapt.

- **Keep evaluating the program.** Regularly look at how the design is working, how patients are doing, whether financial goals are being met, and where there might be room to improve quality or find new opportunities.
- **Foster open communication.** No matter how the care model is set up or how integrated the teams are, it is crucial to keep the lines of communication open at all levels.

13.3. Dr. Frederiksen

Dr. Jad, what are lessons you have learned from successfully combining obesity medicine and bariatric surgery into a more collaborative and integrated practice?

13.4. Dr. Jad

- **Early integration** of obesity medicine and bariatric surgery improves patient outcomes and creates a seamless continuum of care.
- **Patient engagement and education** throughout the care journey increase adherence and satisfaction.
- **Addressing misconceptions**—particularly around the safety and effectiveness of bariatric surgery—is critical to improving referral rates.
- **Identifying and supporting clinical "champions"** accelerates program development and uptake.

13.5. Dr. Frederiksen

These are all very important points! I would like to ask each of you to provide your top 3 pragmatic tips regarding the combined medical and bariatric procedural approach to treating obesity, and what you feel are important areas for future research and collaboration.

13.6. Dr. Shetye

- **Patient care trumps all.** An inter-disciplinary team approach and collaboration is key.
- **Regarding access to care**, treatment of obesity should be a "standard benefit" by insurance providers, not a "carve-out" in policies. This will ensure insurance coverage for both short-term and long-term management of this chronic disease, no different than treatment of cancer.
- **Education of peers and patients is vital.** We as Obesity Medicine specialists need to educate our health-care-professional colleagues regarding optimal evidence-based care for the treatment of obesity and dilute the noise from inappropriate social media coverage.

13.7. Dr. Mattar

- **Expect improved clinical outcomes** as a result of integrated and efficient multi-disciplinary patient evaluation and optimization.
- **Understand the cost effectiveness** of metabolic surgery delivered within an integrated multidisciplinary program, especially when you consider that bariatric surgery provides the patient with a lifetime supply of intrinsic GLP-1.
- **Adopt a continuum-of-care concept** and mindset that incorporates all therapeutic modalities within one integrated clinical entity.

13.8. Dr. Jad

I have 4:

- **Expanding access to care** through telemedicine and community-based outreach.
- **Developing standardized protocols** for pre- and post-operative medical management.
- **Leveraging data analytics**, including patient-reported outcomes, to refine care pathways.
- **Strengthening partnerships** with primary care providers, employers, and insurers to increase referrals.

13.9. Dr. Berger

- **Insurance often requires** a trial period of medically supervised weight loss (MSWL). Most insurance companies want patients to try a certain number of months of MSWL before approving metabolic and bariatric surgery. During this time, patients can also start on an obesity medication to see if it works for them. If it does not, no time is wasted, and they can still decide to move forward with surgery without delay.
- **Losing weight before surgery** lowers surgical risks. Patients who shed extra pounds before their procedure typically face fewer complications during and after surgery. So, pre-operative weight loss is not just about meeting insurance rules, it is a crucial step to make surgery safer.
- **Medical weight loss helps patients transition** smoothly between treatment options. Sometimes, patients start MSWL planning to have surgery but later choose not to. Because they have already been working on their weight and health, it is easier to shift their care further to nonsurgical options without losing momentum.

13.10. Dr. Frederiksen

To conclude our discussion, I would like you each to consider the following scenario: It is the year 2030, you are treating patients with obesity and working at the leadership level at an international organization devoted to improving practice and care of patients with obesity. How would you envision the care you provide, with regard to the comprehensive practice, or how would you envision policy priorities with regard to obesity care?

13.11. Dr. Shetye

I am going to start off with policy priorities. Access to care is a big issue. If related to insurance coverage, I request insurance companies consider obesity treatments as a standard benefit. It is mind boggling that a chronic disease like obesity does not have adequate insurance coverage. Regarding comprehensive practices, I think bariatric surgeons and obesity medicine specialists are invested in the same space for patient care, so that is less of an issue, in my opinion.

13.12. Dr. Mattar

Yes, I think this is one of the misconceptions is that our specialties do not work well together when we can. We all recognize that, in the real world, there are patients who experience weight recurrence. And we all know, whether we are approaching patients from a medicine and pharmacotherapeutic point of view, or a surgical point of view, we struggle sometimes to accurately determine how well the patient will do based on the therapy we prescribe. Frankly, we have a problem in that we lack more personalized approaches to patients. We do not know exactly which operation will be best and we do not know which medication will be best. But I think the bright light that is shining and will help us is artificial intelligence (AI). I think that in five years, we will have accrued much more experience and knowledge about different types of obesity, the different types of metabolic syndrome and perhaps be able to match patients to specific operations or different therapeutic approaches that will optimize their success.

13.13. Dr. Jad

My vision for 2030 is that I want to see obesity care as continuous,

personalized, stigma-free. Patients move seamlessly between medical, endoscopic, and surgical options with equal access. Precision tools, like genomics, digital monitoring, and AI predictive models will guide our treatment, while also considering more equity and access, as with insurance through universal coverage, telehealth, and culturally adapted programs. Every visit should contribute to a real-time learning system focused on outcomes and long-term maintenance. I think the policy priorities would be that obesity is recognized broadly as a chronic disease deserving of full coverage, timely access to care, universal data registry and outcomes-based reimbursement, and that the workforce caring for our patients be trained across the disciplines, as in ASMBS accredited centers. Important would be more global action on reducing stigma around this disease, preventive food policies and last but not least international standards of care that are more universally applied.

As the understanding of obesity shifts beyond BMI toward recognizing it as a complex, chronic disease influenced by metabolic, hormonal, genetic and behavioral factors, comprehensive care must evolve accordingly. This means moving from a weight-centric to a health-centric approach – where treatment decisions are guided by metabolic health, functional status, and patient-centered outcomes. Multidisciplinary teams will need to adopt nuanced assessment tools (such as the Edmonton Obesity Staging System or body composition analysis) to better identify risk, personalize interventions, and improve long-term outcomes.

Future collaboration between Obesity Medicine (OM), Gastroenterology (GI), and Metabolic Bariatric Surgery (MBS) will hinge on shared data and individualized decision-making. AI-driven clinical pathways and predictive analytics will help match patients to the most effective therapeutic modality – pharmacotherapy, endoscopic, or surgical – based on their unique phenotype, genetics, microbiome, and behavioral profile. This integrated model can guide patients to the "right treatment at the right time," optimizing outcomes while minimizing unnecessary interventions. Practically, this could look like AI-supported multidisciplinary rounds where OM, GI, and MBS teams jointly review patient profiles to determine tailored care plans.

Given the scarcity of clinicians with specialized obesity training, health systems will likely be using a tiered or hub-and-spoke model. Regional "obesity centers of excellence" can serve as hubs for advanced care, training, and tele-mentorship, while community-based providers act as spokes for early management and long-term follow-up. Leveraging virtual care and digital education platforms can expand reach, standardize quality, and ensure equitable access. AI-based triage tools could further help stratify patients according to clinical complexity, ensuring that those who need multidisciplinary input most urgently are prioritized.

13.14. Dr. Berger

Everyone summarized my thoughts, but I would emphasize that I agree with educating patients and providers more about the disease of obesity as a chronic disease. I think that is one of my biggest barriers. I do get patients who seem to understand much better than providers. So, I think educating referring providers and patients about the disease would be crucial. And I agree with Dr. Mattar's point that certain medications work for certain patients and different bariatric surgeries work for different patients as well. Some patients are medication responders and some are surgical responders. I think if we can learn a little bit more about that in the future, it would really help guide treatment and improve patient outcomes.

I believe with the movement to define obesity beyond BMI, comprehensive models will become even more important because we will be able to tailor a patient's treatment plan based on the overall goals and health of the patient versus focusing on a BMI or weight number on the scale. These goals will help guide us, instead of one number dictating how to treat the patient. I still think that a number such as BMI is a helpful tool, but it should not be the sole determinant of treatment or measure of outcome.

Hopefully, insurance companies will be covering more endoscopic procedures and also lower the BMI criteria for MBS coverage, as some have already done. This will allow us working in this specialty to more adequately treat those with a lower BMI but with severe metabolic disease or limiting functional status. I also strongly believe that, in the future, healthcare systems and insurance carriers should more strongly encourage and support clinicians with limited experience treating obesity to refer to an obesity specialist, especially when considering obesity medication challenges or decisions regarding MBS. This includes referral to dietitians trained in the care of obesity, as I have seen medical providers take on this role themselves with less than optimal outcomes.

14. Conclusion

14.1. Dr. Frederiksen

Thank you all for your insights. We are at a pivotal moment in obesity care—armed with more effective surgical and medical tools than ever. Recognizing obesity as a chronic condition along with a more diverse set of tools for managing this disease, it is time we take a long-term, whole-person approach.

Our experience and the evidence point to one clear conclusion: multidisciplinary, coordinated care truly benefits patients. It is great to see obesity medicine, bariatric surgery, and endo-bariatrics come together in support of this approach. Over the next few years, I expect more partnerships, richer data in particular with regard to more individualized care, and better outcomes. Among the care models we discussed, integrated or "shared care" systems—like those used in cardiology or breast centers—show the greatest promise. Accredited centers that also hold the Obesity Medicine (OMD) qualification are particularly well-positioned for this type of model. We should also consider a robust accreditation program for obesity medicine practices that provide more evidence-based and collaborative care.

Looking forward, we need research that compares outcomes between standalone and fully integrated models, especially for patients with BMI above 35. We also must adopt a true "continuum of care" mindset, ensuring all therapeutic options—whether alone, in sequence, combined, or as rescue—are accessible throughout a patient's journey.

National collaboration is key. Initiatives like the ASMBS Obesity Summit pave the way for removing barriers, improving access, and driving action. A national network of MBSAQIP accredited centers with OMD designation, supported by robust NIH backing, could revolutionize obesity care—much like the NIH's network of cancer centers does for oncology.

In the end, our goal from this roundtable is to push patient-centered care forward with real-world strategies. While these ideas apply across the spectrum of obesity, we must especially champion those facing the most complex and severe disease—because their needs must always come first.

Thank you!

My three takeaways from this roundtable discussion are:

- Integrated, multidisciplinary and precision care for the patient with obesity shows the most promise for cost-effective care, with more research in this area needed
- A continuum of care mindset is important for all involved in a patient's journey with obesity, much as with other specialties in medicine and surgery
- National and international collaborative initiatives will continue to drive the conversation into action, remove barriers and improve access to all obesity care

Author contribution

KF conceptualized the submission, wrote the drafts, sent questions to

the other authors, and edited the final manuscript. BS, SM, RB, AJ responded to their assigned questions with additions and edits, reviewed their sections for accuracy, and gave final approval of their contribution.

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The Obesity Medicine Association Roundtable represents original works, with work and/or words of others appropriately cited or quoted in the submission. This submission did not involve human test subjects or volunteers. KF was not involved in the peer review process, nor in the acceptance/rejection of this submission. Responsibility for the editorial process for this article was delegated to an independent Editor and/or Associate Editor.

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