The Prevalence and Adverse Outcomes of Obesity Bias and Stigma in Healthcare

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Learning Objectives

- Understand complex pathophysiological processes that lead to obesity
- Understand the prevalence of weight stigma and bias among healthcare professionals
- Appreciate the adverse health effects of weight stigma and bias
- Learn tools and resources to help combat weight stigma/bias in your own practice

Case Presentation 1

- 60 year old postmenopausal female recently moved to the area to be closer to family.
- Has records from her longtime previous PCP in another state.
- PMH: HTN, HLD, chronic back pain requiring small amount of hydrocodone daily
- Pertinent exam findings: Firm, distended abdomen.
    - When questioned further about her body habitus and abdomen, patient reports she first noticed it around menopausal transition and her former PCP had said it was normal for women to gain a lot of weight after menopause. She is interested in weight loss, however.

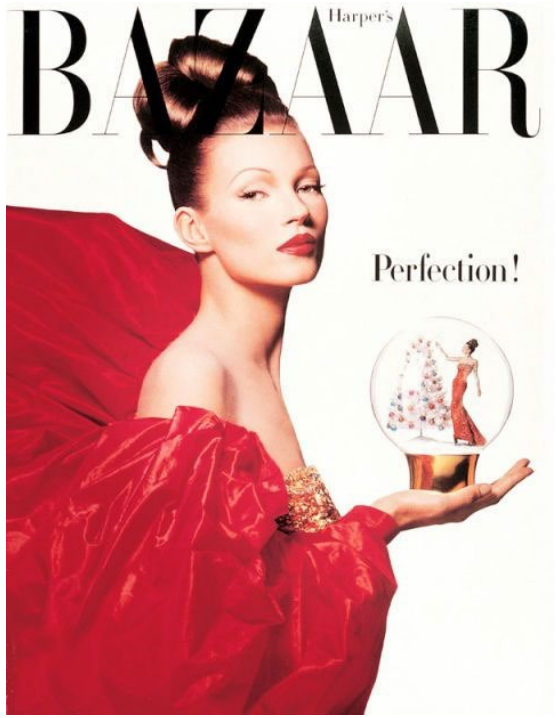
Case Presentation #2

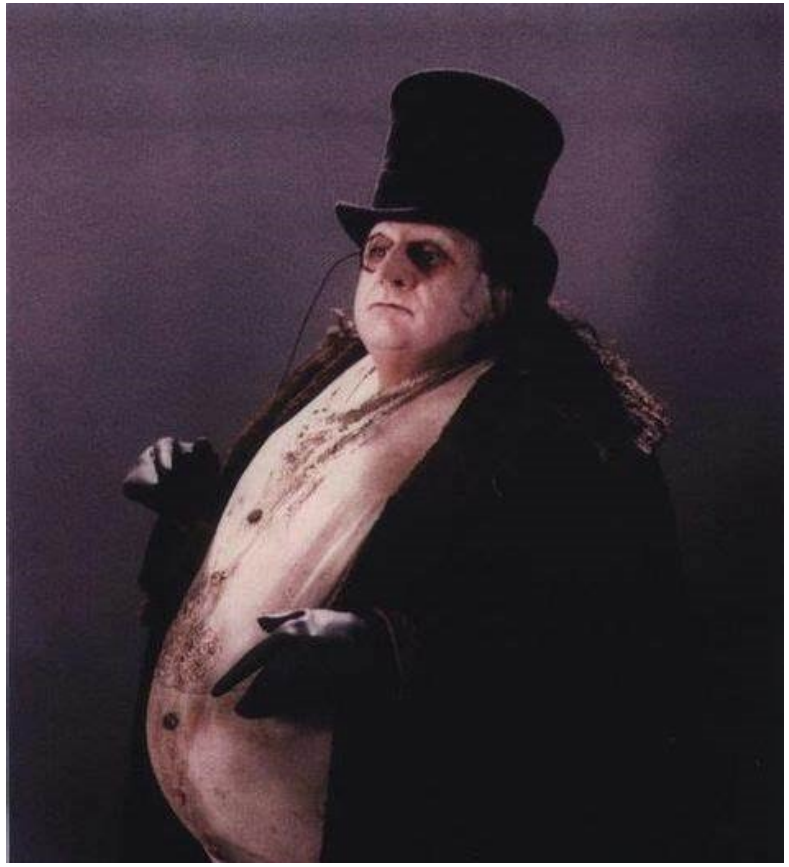
- 39 yo female presenting to medical weight management clinic for treatment of obesity in order to eventually have lumbar spine surgery.
- PMH: DM 2, Depression, Chronic fatigue
- PSH: Gastric bypass surgery in 2014
- Reports chronic fatigue, worsening of depression symptoms, pain and paresthesias of bilateral lower extremities
- Currently taking olanzapine, paroxetine, and lamotrigine for treatment of her depression

What is obesity stigma and obesity bias?

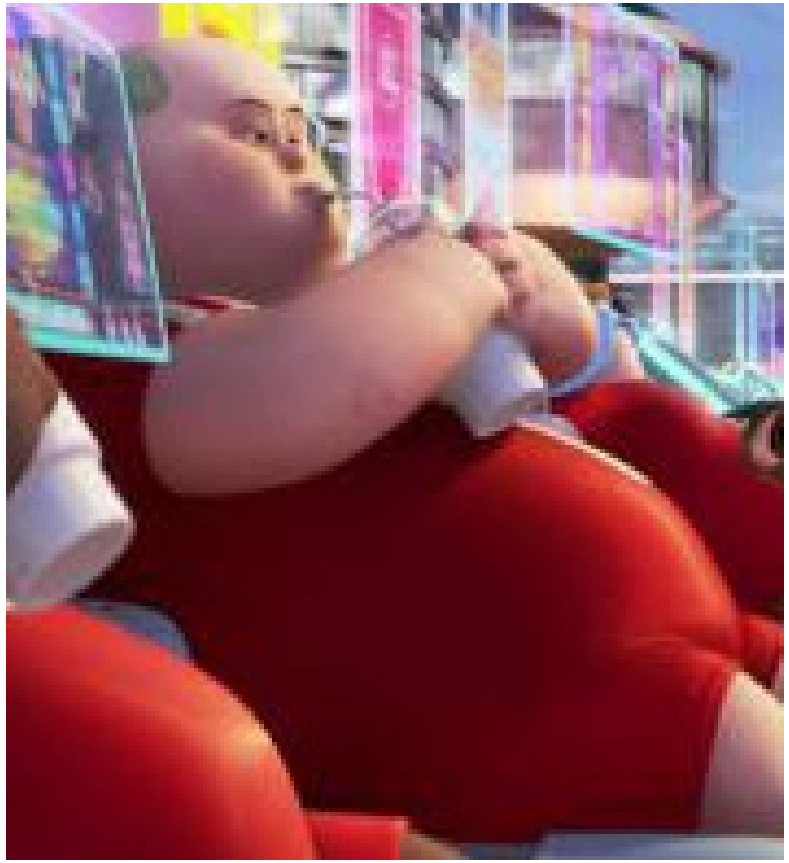
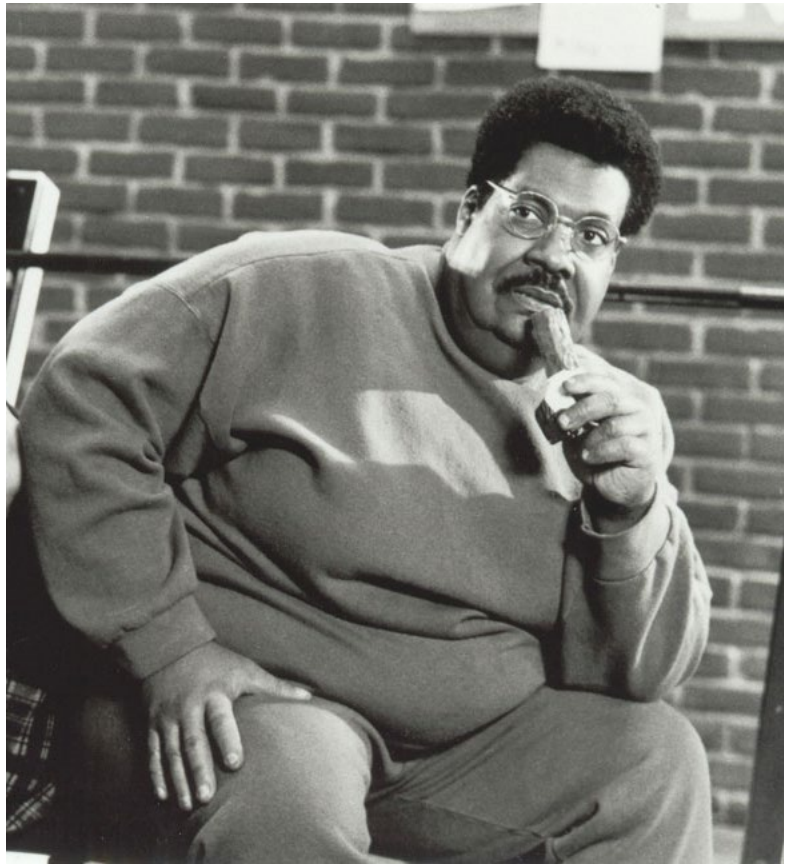
- Often used interchangably, but nuanced distinction exists
- Obesity bias: Negative beliefs and attitudes towards people who have obesity
- Obesity stigma: Actions and effects people with obesity experience due to obesity bias
- Omnipresent messaging in society in a way that is not seen with other forms of bias

Weight and beauty





Weight and moral character


Weight and health status

Weight and personal happiness/satisfaction

Obesity as a disease

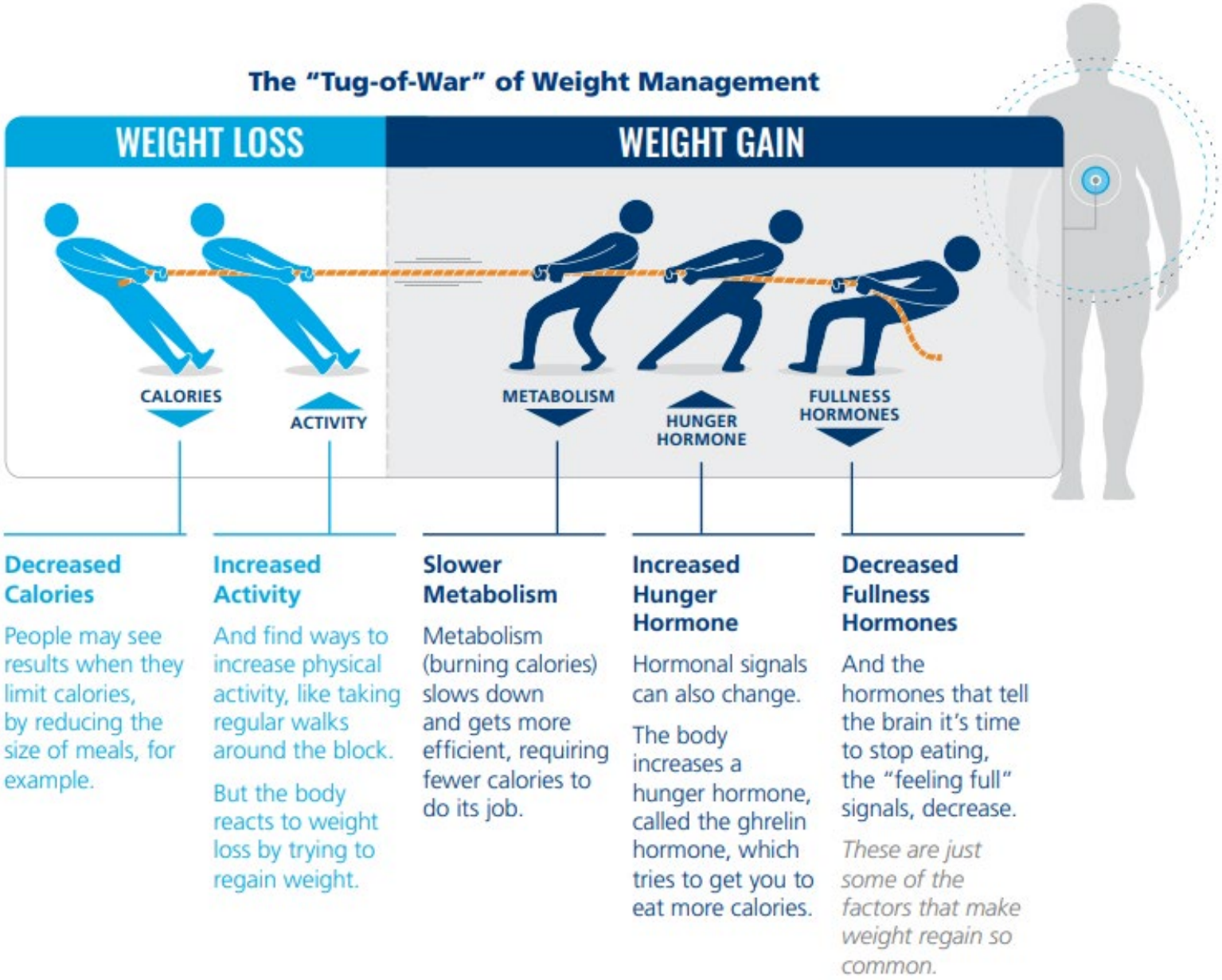
- **Obesity is a disease, not a lifestyle choice**
- Not always recognized as a disease state by organized medicine and policy makers
- 2013 AMA position statement

Obesity Society Position Statement

- "Obesity is a multi-causal chronic disease recognized across the life-span resulting from long-term positive energy balance with development of excess adiposity that over time leads to structural abnormalities, physiological derangements, and functional impairments. The disease of obesity increases the risk of developing other chronic diseases and is associated with premature mortality. As with other chronic diseases, obesity is distinguished by multiple phenotypes, clinical presentations, and treatment responses."

Why is it so hard to lose weight?

- Thousands of years of human history did not select for genes promoting weight loss
- The human genome cannot adapt rapidly enough to account for our current environment, especially food environment
- Our bodies consistently fight weight loss efforts



From "Rethink Obesity" website, courtesy Novo Nordisk

↓Leptin

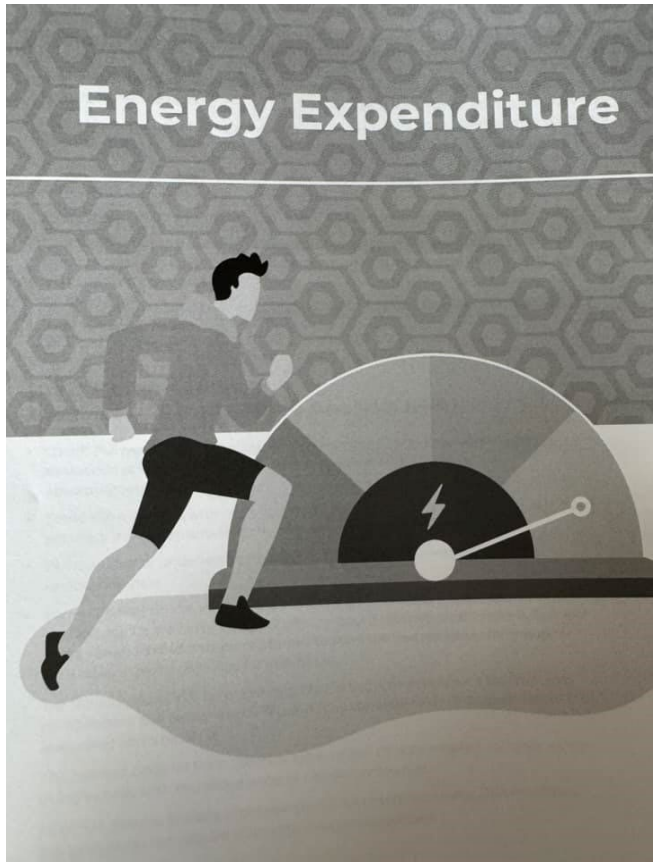
↑Ghrelin

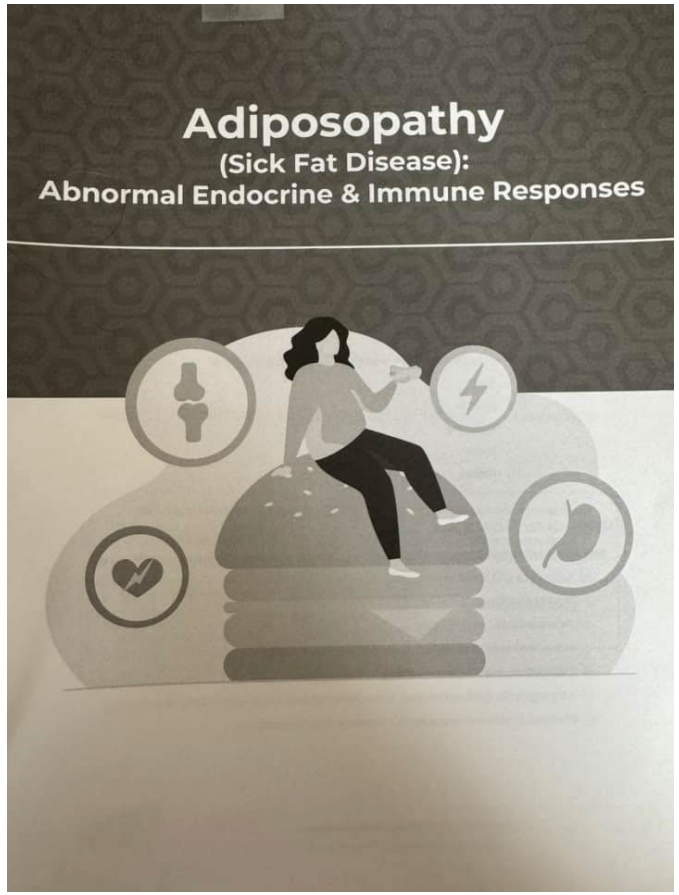
↓Resting metabolic rate
↓Energy expenditure

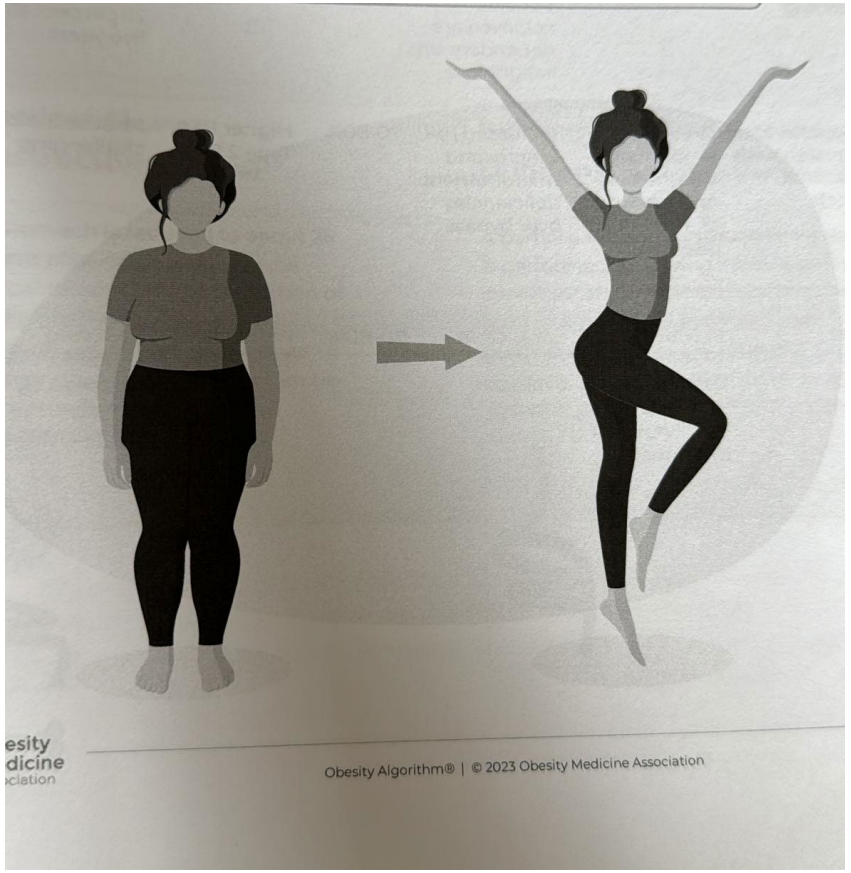
Obesity bias/stigma in healthcare settings

- Present in all healthcare settings
- Present in education
- Present in healthcare policy

Even present in official obesity treatment algorithms!

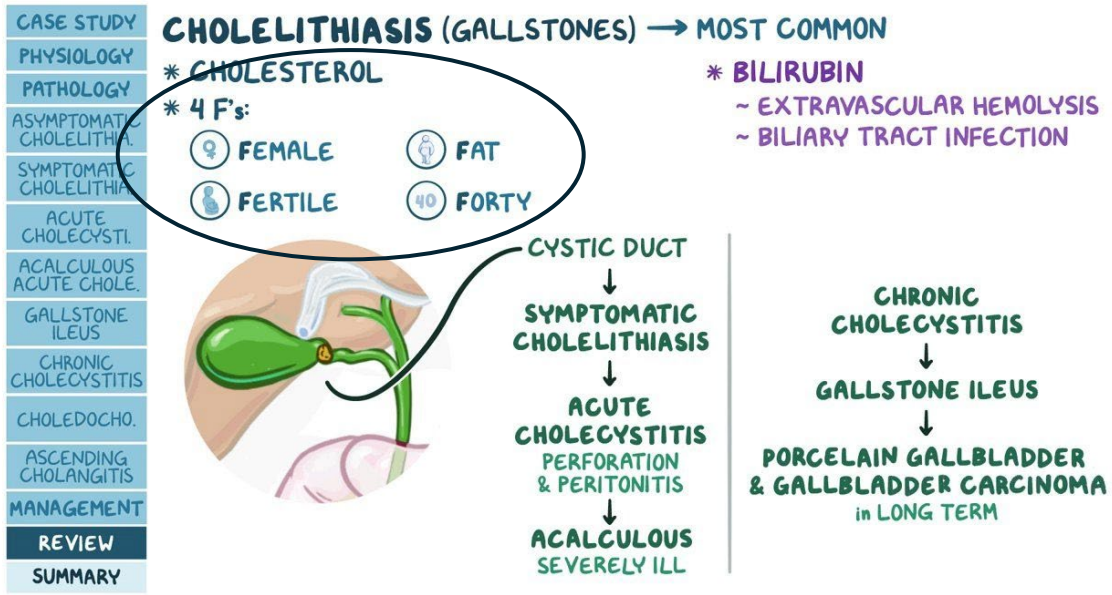






Obesity bias in health education

- Medical school memory devices
  - 4Fs of gallbladder disease



- Overemphasis of obesity as a risk factor

Common biases in healthcare professionals

- Patients with obesity consistently report the experience of obesity stigma and bias in their healthcare system interactions
- Large meta-analyses demonstrate obesity bias in all healthcare professional groups
  - Physicians, nursing professionals, medical students, nursing students, podiatrists, PT, OT, dieticians, speech pathologists

Common biases in healthcare professionals

- Common obesity biases self-reported by healthcare workers:
  - Visits with patients with obesity are more likely to be a waste of time
  - Patients with obesity are less likely to be adherent to treatment plans
  - Patients with obesity are lazy, undisciplined, or week
  - Obesity is likely the cause of a patient's conditions and symptoms
  - The patient's lack of willpower is to blame for any health complications and treatment failures they experience

Patient-reported obesity bias

- 70% of patients with obesity report having experienced weight bias from healthcare professionals
- Report consistent lack of belief from the HCPs that they are truthfully reporting their diet and exercise habits
- Troublingly common reports of patients' weight being blamed for devastating outcomes such as pregnancy loss

Healthcare coverage and policy

- Insurance coverage has some of the most glaring obesity stigma present
- No legislative protection or mandates for coverage of obesity unlike other highly-stigmatized conditions such as mental health, substance use disorders

So what?

- Weight bias and weight stigma has numerous long-reaching adverse effects on patients' health
- These adverse effects are seen in studies even when controlling for BMI and other comorbidities
- These adverse health outcomes include missed diagnoses as well as persistent gaps in preventive healthcare measures

Mental Health

- Higher rates of disordered and maladaptive eating patterns
  - Patients who have experienced weight bias and stigma are more likely to engage in unhealthy eating habits such as skipping meals, binge-eating, eating in secret, purging behaviors, etc
- Higher rates of depression and anxiety
- Again, we see these even when we control for other comorbidities and for BMI

Physical complications

- Increased rates of
  - Hypertension
  - Chronic pain
  - Hyperglycemia
- Bariatric patients who experience weight stigma and bias have less overall weight loss after surgical intervention
  - Bariatric surgeons are just as prone to weight bias as other groups of HCPs

Poorer outcomes in weight loss efforts

- Overall decreased success in weight loss programs
- Less likely to engage in healthy behaviors
  - Unhealthy eating behaviors as mentioned previously
  - Less likely to engage in exercise
    - Gyms and exercise programs are extremely biased environments against individuals with obesity
- Some studies have shown increase in inflammatory markers which can counteract weight loss efforts

Relationships with clinicians

- Much more likely to underreport symptoms and problems
- Less likely to receive important screenings such as mammograms and pap smears
- Higher risk for complications of disease states because of underreporting of symptoms
- Fear that their clinicians will blame their weight and not listen to their concerns

Internalized bias

- Internalized weight bias is seen just as internalized bias of other forms
- Patients who report internalized weight bias, in addition to externalized weight bias, have even higher rates of adverse health outcomes

Case Presentation Review

- Case 1: 60 yo female with chronic back pain and abdominal distension. Distension previously believed to be menopause-associated weight gain.
- Case 2: 39 yo female with BMI of 50 and past surgical history of gastric bypass, presenting for weight loss. Chronic back pain with paresthesias of bilateral extremities, significant chronic fatigue, and depression.

Case 1

- Reviewed records from outside PCP and found no record of abdominal imaging
- Lots of documentation of discussion of weight loss efforts
- Initial labs showed elevated creatinine so renal ultrasound was ordered initially
- Renal ultrasound showed…

Case Study 1

- A 38 lb ovarian mucinous cystadenoma
- Urgently referred to gyn onc at WVU and had removal and staging
- Thankfully confirmed to be benign
- BMI in normal range after surgery with resolution of chronic back pain

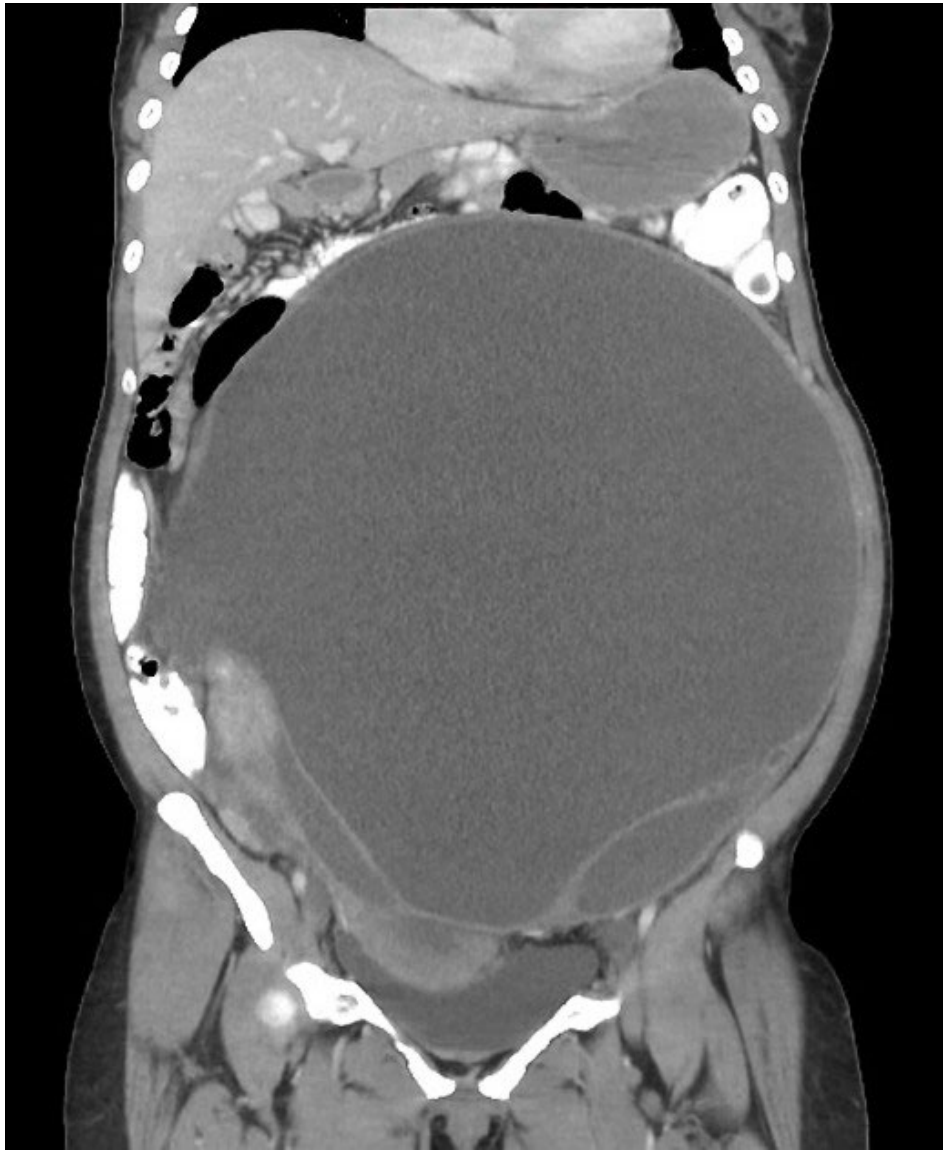


Image courtesy Radiopaedia.org

Case 2

- Review of patient's chart and history revealed that she had not had any post-bariatric surgery nutritional labs since her initial post-operative visit in 2014
- When asked about why this had happened, she reported that her surgeon had made her feel ashamed for not losing more weight and she did not want to go back to see him
- Subsequent PCPs had also not done nutritional monitoring and had documented that patient's fatigue was due to obesity

Case 2

- I ordered all recommended post-bariatric surgery labs which revealed several vitamin deficiencies
  - Vitamin D 25 of 16.8 ng/mL (normal 30-100)
  - Serum iron of 28 mcg/dL (normal 45-170)
  - Serum zinc of 53 mcg/dL (normal 60-130)
  - Serum copper of 271 mcg/dL (normal 70-175. Elevation likely secondary to zinc deficiency)

Case 2

- Appropriate replacement of deficient vitamins initiated
- Diet and exercise regimen also recommended with increase in healthy vegetables, protein intake of at least 80g/day, 10 minute home chair exercise workout daily
- Returned to clinic 1 month later with decrease in waist circumference, improvement in Zn and Fe levels, as well as overall improvement in energy and decrease in pain levels

Combating weight bias in your practice

- Weight bias is widespread
- The rule rather than the exception in most healthcare settings
- Requires personal reflection and awareness as well as tangible efforts to make healthcare settings welcoming and nonjudgemental spaces

Personal reflection

- Fighting weight bias starts with you
- Weight bias can be internalized and unrecognized like any other form of bias
- What are your own feelings about patients with obesity?
  - Do you consider their weight to be a personal failing?
  - Do you think if they ate less and did more that they would not have obesity?
- Do you find yourself frequently annoyed or angry with them?
  - Do you feel like they're not trying hard enough?
  - Do you feel like you can't help them?

Personal reflection

- Pay attention to the many, many ways that society and culture messages us about weight
- Question yourself if your explanation for a patient's symptoms is simplified to "their weight"

Call out bias when you see it

- As clinical leaders, it is your role to speak up when other staff and colleagues are making biased statements or behaving in a stigmatized manner
- Remind colleagues and staff not to use pejorative language for a person's weight (calling them fat, huge, etc)
- Have zero-tolerance for weight bias and weight-shaming in the same way that you have zero-tolerance for other forms of bias and discrimination

Use person-first language

- **It is never "the obese patient"**
- **It is ALWAYS "the patient with obesity"**
- Person-first language places the individual before their disease state
- This in turn ensures we continue to see them as complex humans and do not reduce them to a single aspect of who they are

Other tips

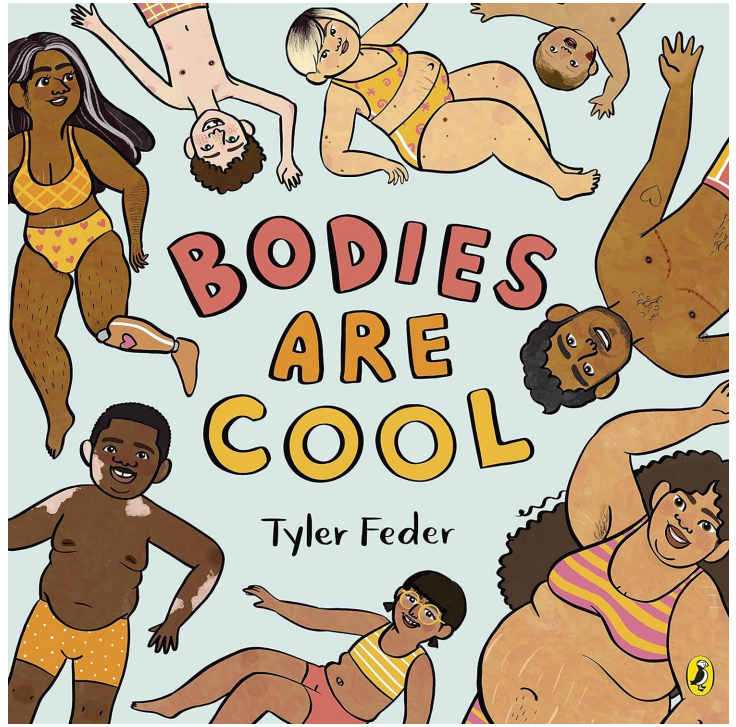
- Ask permission before discussing a patient's weight with them
  - Trust me, they know if their weight is higher than it should be.
  - If they have experienced weight bias and stigma in healthcare before, launching into a discussion of their weight can damage the therapeutic relationship
- Don't shame, cajole, berate, or guilt patients into attempting weight loss

Other tips

- Weigh patients in private locations where others cannot easily see or hear their weight
  - Ask before weighing the patient
  - For adults, do you really need to weigh them every single visit?

Resources

- For kids
  - Weight bias and stigma—both external and internalized—starts in childhood
  - Positive messaging about body types is imperative
  - Bodies Are Cool
- For patients
  - Obesity Action Coalition
- For clinicians
  - Obesity Action Coalition
  - Obesity Medicine Association
  - Obesity Care Advocacy Network



OAC
Obesity Action Coalition

Conclusion

- Obesity stigma and bias is a pervasive problem in all fields of healthcare
- It has significant adverse health outcomes for patients