

Chapter 2

Prejudice, Discrimination, and the Preferred Approach to the Patient with Obesity

Key Message

Discrimination and prejudice against people who suffer from obesity is an unacceptable treatment environment within healthcare. In the last 10 years, prejudice against obesity has increased by 66 %. Obesity bias and discrimination is widespread both in society and among healthcare workers. In the healthcare environment, bias leads to inconsistent evaluation and management of obesity, discourages the patient from seeking care, and increases the cost of care. To eliminate bias, practitioners and staff must first identify their personal attitudes and misinformed beliefs about obesity. This can be done through the use of specific survey tools. Physicians and health care staff should adopt nonjudgmental ways of talking effectively with patients using motivational interviewing techniques (MIT) and self-determination theory. After that, a framework can be developed that provides consistent, blameless, sensitive and effective care for those patients who suffer from obesity. An important part of that unbiased framework of care is routine clinical measurements of each person's level of obesity through the universal use of Weight Related Health Indicators (WRHI) (i.e. measurements of BMI, Waist Circumference and Body Fat Percentage). Many overweight patients are in denial or simply unaware of their level of obesity and their potential health risks. Thus, measuring and recording the patient's WRHI and then sharing that information with the patient every time they encounter the healthcare system is of paramount importance if we want the patient to be fully informed and engaged in their own care.

Learning Objectives

1. Understand key principles regarding obesity-related prejudice and discrimination.
2. Identify personal attitudes and misinformed beliefs that may contribute to obesity bias in the practice for all staff and providers.
3. Learn and incorporate Motivational Interviewing Techniques (MIT) in all patient interviews with a focus on the patient with obesity.

4. Develop a framework to provide a blameless, sensitive, and engaging environment for staff and providers to identify, understand, and optimally treat those patients who suffer from obesity.
5. Communicate the Weight Related Health Indicators (WRHI) to patients in each visit using the Weight Related Report Card (WRC).

The Patient's Perspective

The feelings expressed below are a compilation of many patients' perspectives, and are very common among patients who are obese. It is essential for health care providers to recognize and understand the magnitude of these feelings.

I was big even as a young boy. Looking back at photographs from my elementary school, I immediately see that I was so much larger than the rest of the kids. These photographs always show me in the middle, with thin people on either side. It was humiliating when I was the only one left standing as teams were being picked. A teacher would eventually assign me to a team, but the other team members clearly resented the burden of having me on their team, and I rarely actually played the game. As a teen-ager I took comfort in food. Food never criticized you. I wasn't really athletic, but "found myself" in my schoolwork. Using my brain gave me some positive feedback. As I got older my weight became a more substantial problem. I was treating my anxiety and my boredom with food but I felt helpless to stop it. Food gave me comfort.

I started to try and do something, anything, about my weight, realizing how much it was affecting my opportunities and my social interactions. My attempts to lose weight have led me to trying different diets, reading a handful of books, and surfing the Internet for new information or clues, but honestly I have no idea what is true about obesity and what is not. I guess the reason for my obesity is obvious: I eat too much, I don't exercise regularly, and I'm emotionally screwed up. The answer from professionals and healthcare providers is simply to reverse those factors. But it feels impossible for me to achieve and sustain weight loss. Repeated cycles of failure to overcome my weight problem have devastated my self-image. I have become progressively defensive, angry, depressed and withdrawn. The media and the Internet constantly reinforce my poor self-image.

I can't remember at what point in time I realized that the looks I get from people around me are looks of disgust and loathing. No matter how good a person I try to be, or how much I try to please others, my good characteristics can't seem to break through. I feel there is literally no help for me. Even when I go to the doctor I am not sure they really see "me". The fact that I am 100 lb overweight doesn't seem to matter anymore – I don't think they really understand, or know how to help me.

As a medical practitioner, it is essential that you put yourself in the shoes of the person with obesity. The pain of obesity is profound and life changing. It must be met with empathy and direct, specific clinical care; not with bias, avoidance, or confrontation.

Discrimination, Prejudice, and Weight Stigma

Patients suffering from obesity experience widespread discrimination and prejudice everywhere they turn. The "big" person sitting in your front office is the residual personality forged from years of assumptions and negative reactions from society in

general. A “big” person is unique in our environment. They may find it difficult to fit in, socially or physically. People avoid making eye contact with them when they are trying to find a seat on the plane. They cannot fit in many of the seats or booths in a restaurant. People watch what they order, and how and what they eat. The person with obesity often encounters open scrutiny from strangers, and can suffer verbal abuse and negative judgment from society as a whole. All of which, in turn, fosters depression and despair, adding to insecurity about their ability and self-image that may already be felt by a person with obesity. In adolescents who are obese, this discrimination often results in bullying and physical abuse [1].

Some of the most painful discrimination is suffered at the hands of family members, romantic partners, and friends. Women are more often victimized than men in these settings. In the workplace, up to a third of people with obesity are paid less and experience discrimination that includes wrongful termination, not being promoted or not even being hired [1].

The media is another source of discrimination, portraying people with obesity as bumbling, stupid, or negligent, and depicting obesity as a personality flaw, a lack of personal control, or as the object of humor [2]. The media often will focus on the cost of obesity to society for example in the increased cost of health care. The expense of obesity may also drive prejudice.

August 12, 2009, David Leonhardt of the NYT wrote about Delos “Toby” Cosgrove, MD CEO of the Cleveland Clinic, “Cosgrove says that if it were up to him, if there weren’t legal issues, he would not only stop hiring smokers. He would also stop hiring obese people.”

Creating a Culture of Safety for the Patient with Obesity

Before engaging in the specific treatment of obesity and related disease, I was no more “aware” of the patient with obesity than the average practitioner. I recall the day that we brought new chairs into the gastric bypass clinic that were “roomier” for bigger people. The first patient who came in sat down and then burst into tears, saying she had never been in a doctor’s office where she had been able to sit comfortably and without embarrassment in a chair. What may seem like an obvious office necessity to you may be a symbol of acceptance and care to your bigger patients, signaling a supportive, empathetic environment.

– Robin Blackstone, MD

The Current Healthcare Environment Is Prejudiced Against People with Obesity

Americans persist in their prejudice against the person who is overweight and obese. In the last 10 years, prejudice against obesity increased 66 %, while prejudice against age and race remained relatively constant [3].

Physicians have the same level of prejudice as the general public and this bias prevents patients from seeking timely and effective medical care [4, 5]. Over 50 % of primary care physicians view patients with obesity as unattractive, awkward, ugly, and noncompliant. Moreover, 44 % of physicians feel they are unqualified to treat obesity and 31 % of physicians feel that treating obesity is futile. These same physicians rate the treatment for obesity as being less effective than 9 out of 10 treatments for other chronic diseases [6]. Research further shows that physicians believe that only 2.5–3.15 % of their patients are motivated to lose weight. However this view that patients with obesity are not motivated for change is incorrect. In fact, 30 % of female patients and 21 % of male patients with obesity are very motivated to change [7].

Physicians are not the only health care providers who are biased against the obese. Medical students report that the patient with obesity is most often the target of humor during training [8]. The same bias exists in nurses, dieticians, and exercise physiologists. The very group of people being counted on to care for the obese are so influenced by their own bias that, wittingly or unwittingly, they cannot help but negatively affect the quality of care.

What is your own personal reaction when you see a person who is obese? Do the feelings that come to mind invoke incredulity, curiosity, disgust, or revulsion? Do you immediately assume that person is ignorant? Lazy? Self-indulgent? These negative reactions are rarely hidden successfully from patients and they compromise a provider's ability to connect with their patient and engage them in their own health. On a broader and more far-reaching scale these negative assumptions and reactions provide the wrong leadership model for the clinical setting.

Changing the Current Healthcare Environment from Biased to Blameless

Changing the current healthcare environment from one of bias and prejudice to one of understanding and blameless support requires the identification and quantification of obesity bias in the staff, colleagues, and oneself. To this end, both **explicit** (deliberate/verbal behavior) and **implicit attitudes** (spontaneous/nonverbal behavior) are areas where physicians and staff need (1) sensitivity training, and (2) Motivational Interviewing Technique (MIT) training [5]. Explicit attitudes are easier to monitor and regulate if a no-tolerance policy against deliberate/verbal obesity bias is implemented; this in turn creates a blameless and safe clinical environment.

Tackling the implicit cues that patients receive, however, is more difficult. It may be best to start by doing an in-house survey. Consider administering the Implicit Association Test and the Fat Phobia Scale to yourself, your staff, and your colleagues in your particular healthcare setting. This will identify the level of obesity bias that exists, and will identify specific areas of improvement that can be discussed as a group.

Controlling and ultimately conquering obesity bias in the healthcare setting is not accomplished simply by providing staff with sensitivity and MIT training. A second, even more critical step is necessary: making staff and colleagues aware of the **biological bases** that causes obesity. Understanding the most current science surrounding the biological bases for obesity may be the single most effective catalyst that transforms the current healthcare environment from one of bias and blame to one of engaged understanding and optimal treatment.

The Blame Game: Why Blame the Patient for Their Obesity When We Do not Blame Them for Their Allergies, High Cholesterol, Hypertension, or Cancer?

Blame is assigned to the patient with obesity primarily due to one fact: the person with obesity is widely believed to be personally responsible for the lack of control over his/her weight.

Physician bias in believing that the patient is personally responsible, as surveyed in the Fat Phobia Scale, correlates with negative attitudes toward the obese [9]. Large-scale surveys of physicians cite lack of physical activity as the main cause of obesity, with consumption of high-fat and high-sugar foods as the second highest cause. Both of these perceived “causes” of obesity are directly attributed to the personal choices of the patient. In addition, 50 % of physicians feel there is an additional psychological or emotional component that contributes to the patient’s lack of self-control, and may prevent patients from achieving weight loss [6]. Indeed, physicians often cite the patient’s emotional “addiction to food”. Addiction is a medical term attributed to a *physiologically* and *biologically* driven impulse, not an emotional or psychological impulse.

Based upon these widespread but outdated beliefs, physicians may feel it is acceptable not to bother “treating” obesity at all. Alternatively, the physician may become inconsistent in their efforts to address and treat obesity, leaving most patients with obesity to cope with their disease on their own.

The view that the patient with obesity is personally responsible for his/her excessive weight is, at best, medically incomplete. Obesity is primarily a physiologically/biologically driven disease; *not* primarily a psychologically/emotionally driven one. Psychological issues complicate obesity not unlike obesity-related disease complicates obesity. The current, widespread beliefs and discrimination surrounding obesity is based on an outdated and incorrect understanding of science.

The history of medicine contains a multitude of examples where prevailing, widespread beliefs were simply wrong. For instance, for many years physicians were taught and believed that stress, and the subsequent increase in acid production in the stomach, was responsible for peptic ulcer disease. Treatments were proposed and enacted upon thousands of patients based on this understanding. Then one day, a scientist demonstrated that the causative agent of peptic ulcer disease was a simple

bacterium, *Helicobacter pylori*. The disease was treatable with antibiotics. Ulcer disease disappeared virtually overnight. Once the underlying medicine and science was correctly understood, effective treatment was established.

The science of obesity is in a similar state of misunderstanding. The limited education we give patients and the methods recommended to manage obesity are based largely upon societal preconceptions and one's own personal beliefs, not on the most current, informed science. It is no wonder the outcomes of one's "treatment" are poor and the disease recurrence (weight regain) rate is so high.

Inability or Unwillingness to Overcome Bias Against Obesity and Its Effects

If the bias against obesity in a particular healthcare environment is so strong it cannot be overcome that particular healthcare environment should limit the inclusion of obese patients. Initiation of the doctor–patient relationship in the clinical setting is voluntary. The American Medical Association (AMA) provides guidance to physicians in Rule 10.5, permitting the refusal of services to a patient if the required treatment is: (1) beyond a physician's level of competence, (2) not medically indicated, or (3) incompatible with the physician's personal, religious, or moral beliefs [10].

Although physicians are not allowed to refuse care based on race, gender, sexual orientation, gender identity, or any other criteria that constitutes treating a protected class of persons unequally in a manner that is malicious or damaging (i.e., invidious discrimination), this prohibition does NOT extend to overweight or obese persons, who account for nearly 66 % of the general population. More significantly, that 66 % of the population routinely seeks health care primarily because they have become sick with obesity-related diseases. Obviously, excluding 66 % of the population from your practice would be impractical and perhaps unethical. To remain relevant and have a successful practice, each provider needs to understand, educate, and overcome personal bias. These changes will better serve the majority of patients. Key questions to ask oneself are:

1. Are personal beliefs biased?
2. Is that bias promoting a subtle discrimination against the patient with obesity, thereby making your recommendations less effective or so off-putting that the patient with obesity does not seek timely care?
3. Are personal beliefs influencing the cost of care because patients who experience bias avoid care? Has the team considered how bias affects care and outcomes [11]?

How Obesity Bias Negatively Affects Medical Care and Outcomes

Discrimination and obesity stigma create a perfect storm. It starts with the fact that even patients with BMI in the overweight range of 25–39.9 kg/m² can have increased levels of obesity-related disease. As BMI increases, so does the prevalence of related disease (Fig. 2.1).

Large research trials have shown that patients with obesity-related disease (including type 2 diabetes, hypertension, high cholesterol/lipids, obstructive sleep apnea, degenerative joint disease, and/or gastroesophageal reflux) who also experience discrimination and stigma are more likely to avoid seeking medical care until the disease manifests in a higher acuity [12].

For example, breast and colorectal cancer are both associated with increased frequency and acuity at the time of diagnosis in patients with obesity. Yet regular cancer screening is less frequently accomplished in patients with obesity, despite the fact that preventive screening for both breast and colorectal cancer significantly increases detection rates [13]. This is just one example of how obesity bias negatively affects medical outcomes.

Discrimination and obesity stigma also affect the physiology of patients. In one carefully controlled study, the stress response of women exposed to video clips featuring jokes and vignettes about overweight and obesity was measured by their rising cortisol levels. The initial hypothesis was that women who were obese would have an increase in their level of stress and cortisol. Surprisingly, the results demonstrated that ALL women, including normal weight women, had an increased level of stress and free cortisol after viewing the material featuring abuse of the patient with obesity. This physiological connection between the patients’ exposure

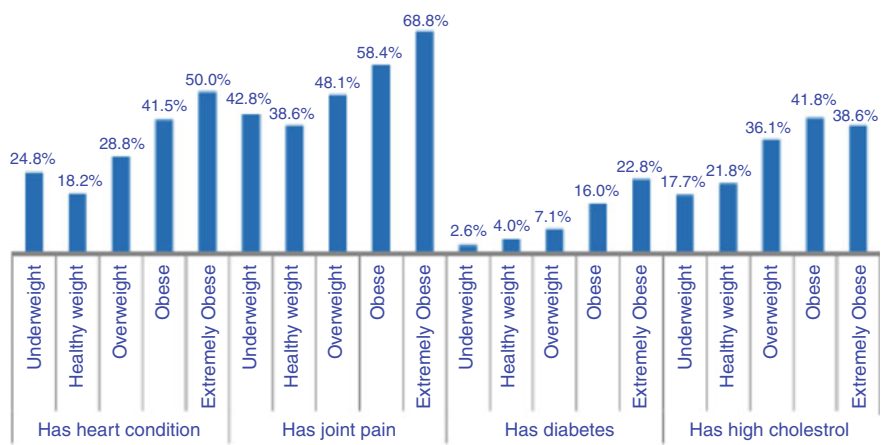


Fig. 2.1 Percentage with selected comorbidities by BMI categories, adults age 20 and older, 2009 MEPS (from Carroll and Rhoades [18])

to discrimination and increased stress may trigger additional adverse effects such as hypertension, high heart rate, increased blood glucose, and other physiological health risks that are caused or exacerbated by higher cortisol levels [14].

The Importance of Communicating the Measurement and Identification of Obesity of All Patients Within a Healthcare System

Many overweight patients are in denial or simply unaware of their level of obesity and their potential health risks. Thus, measuring and recording the patient's personal Weight Related Health Indicators (WRHI) (BMI, Waist Circumference and Body Fat Percentage) and sharing that information with the patient every time they encounter the healthcare system is of paramount importance if we want the patient to be informed of his/her current health status, and potential health risks [15].

Some physicians and psychologists have advocated NOT measuring or sharing BMI factors with the patient, as they are concerned the patient may get angry and defensive, or view it as discriminatory. Their main objection to measuring the level of obesity appears to be that it will increase stigma [16]. This view may be true when measurement and communication of BMI is haphazard and inconsistently applied from patient to patient. But rather than abandon measurement and effective education around the result, the goal can still be achieved in a way that avoids discrimination and bias. Making the measurement and communication of WRHI part of the standard process for all patients for every visit will accomplish this goal. Measuring and sharing a patient's Weight Related Health Indicators should be no different than measuring and sharing a patient's blood pressure, pulse, or temperature. In addition, this feedback should be provided to patients in a timely way so that it provokes a consultation/discussion of BMI and obesity-related disease, when warranted, at the earliest opportunity.

One way to facilitate that essential communication step with the patient to promote education and understanding of weight-related health is for patients to receive a color-coded "Weight Related Report Card" containing their vital statistics of BMI, Waist Circumference and Body Fat Percentage. The color assigned would reflect the individual's level of risk and reflect a composite risk score that accounts for how the waist circumference and body fat percentage affect risk (Table 2.1). This allows you to accurately and succinctly capture and communicate the weight-related health indicator (WRHI) data in a way that makes sense to patients. The electronic health record will allow validation of the risk scoring system by correlating the personal clinical history of the patient over time with the development of their personal history with obesity and related disease in a real-world setting.

For example, the patient with a normal BMI (less than 25 mg/kg²) would receive a green card, unless his/her weight circumference or body fat percentage were above healthy levels, than they would be in the yellow zone. This allows for special

Table 2.1 Adult weight related report card based on weight related health indicators

		Range	Points	Score
BMI		18.5–24.9	0	
		25.0–29.9	1	
		30.0–39.9	2	
		> 40	3	
Waist circumference	Male	≤40 in	0	
		≥40 in	1	
	Female	≤35 in	0	
		≥5 in	1	
Body fat %	Male	≤25	0	
		≥5	1	
	Female	≤35	0	
		≥35	1	
Health report card			Total Points	

Total Points	Health Report Card
0	Green
1	Green
2	Yellow
3	Orange
4	Red
5	Red +

populations, which carry weight centrally, to be more accurately evaluated in regards to risk. The patient with a BMI of 25–29.9 kg/m² might also receive a green card if his/her waist circumference and body fat are within a healthy range. On the other hand, they may get a yellow or orange card urging caution if either waist circumference or body fat percentage are outside healthy guidelines. The patient with a BMI of 30–39.9 kg/m² most often will receive an orange or red card, indicating a more advanced level of risk; however the system also accounts for the athlete who maintains a higher BMI but healthy weight circumference and body fat percentage (green/yellow). A patient with a BMI of 40 kg/m² or greater receives a red card, indicating that they are in the danger zone and need to take steps to immediately address the health risks they face regardless of any other factors. Risk is a concept often difficult for patients to grasp. The use of color-coded cards would provide a familiar paradigm of risk that people are used to seeing: yellow means caution, proceed with care and knowledge. Red means that continuing unchecked may result in a fatal accident at worst and a ticket at best. The patient may get away with running a red light now and then, but eventually the risk of negative consequences increases. This system of using the Weight Related Report Card (WRC) would open the door to an ongoing conversation between doctor and patient about obesity and its corresponding health risks. The WRC system might also provide an immediate, visible signal to the healthcare provider and team that there may be more going on medically with the patient in regards to a standard physical complaint. It allows for the rapid assessment of weight gain between visits and may suggest an association with a particular intervention, like prescribing an antidepressant or other drug that causes weight gain. A patient may say, “Last time I was here with an ear infection I was in the yellow zone, now I am orange. What should I do?” The Health Report Card for WRHI is a communication tool.

If **ALL** patients were to receive information about their BMI, there would be no “singling out” and no discrimination. Some patients may feel a measure of

discomfort initially in being given their WRHI statistics and WRC, having themselves been in denial of the level of their obesity for some time. However, as they voluntarily seek help by coming to see a medical practitioner in the first place, where better to find it than with a trusted healthcare provider who approaches the problem with quantitative data, empathy, and a clear understanding of the new science of obesity.

Measuring patients' BMI and discussing the results with them may also avoid the "black hole" of obesity management. Consider this common scenario: The healthcare provider mentions, almost in passing, that the patient needs to "push away from the table" and get some exercise, or similar words to that effect. In a follow-up visit, it becomes clear that the patient has failed to lose weight, and the patient may feel the despair of failure. Likewise, the provider may feel frustration at what he/she perceives as a lack of compliance. This scenario is repeated over and over until both sides simply stop talking about obesity. Avoiding this "black hole" of treatment requires a deeper understanding of the actual biology and pathophysiology of obesity that, in turn, will translate into a treatment paradigm that actually works [17].

In sum, changing the biased culture in our healthcare environment is the crucial first step to effectively treating obesity and obesity-related disease. Discrimination and obesity stigma must be recognized and overcome. Personal beliefs and those of the staff should be objectively examined. Sensitivity to the patients' perception of stigma should be discussed, and specific training should be implemented to diminish and eliminate discrimination and bias in the workplace. Creating a blameless and supportive environment will allow you to approach this sensitive and difficult topic with empathy.

The second step in effectively recognizing and treating obesity and obesity-related disease is to implement a mandatory, universal, non-discriminatory protocol of measuring every patient's WRHI as outlined in Chap. 1. Those objective, clinical measurements can be used, where appropriate, to open a dialogue about obesity, obesity-related disease, and treatment.

How to Talk with Your Patient About Obesity—The Preferred Approach

Human beings have a tendency to judge others. Therefore, medical providers are trained to avoid the countertransference of negative judgment to patients while simultaneously remaining aloof from personal responses that might endanger the therapeutic relationship. This aloofness and distance is not the best way to engage patients in their own care. Patients want and need a personal response to them as people. In the latest Medical Expenditure Panel Survey (MEPS), overweight and obese patients received a doctor's advice about exercise or about the dangers of eating high-fat foods less than 50 % of the time [18]. Effective treatment requires an

authentic interest in the patient's health. The traditional method in obesity treatment involves encouraging a patient to personally change his/her behavior through food intake and exercise. This foundation of behavior change will be a part of every treatment strategy currently available. To achieve that goal, the best tool is Motivational Interviewing Techniques (MIT). When these interviewing techniques are used consistently they are effective with patients who suffer from obesity [19].

MIT is defined as “a client-centered, **directive** method for enhancing intrinsic motivation to change by exploring and resolving ambivalence [20].” There are four tenets of MIT:

1. The expression of empathy
2. The development of discrepancy
3. Rolling with resistance
4. Support for self-efficacy

The Expression of Empathy

The first foundational tenet and best predictor of behavior change in the patient is the expression of empathy by the provider. In order to maximize this approach, it is critical that the provider/staff members first acknowledge and resolve any personal bias about overweight and obesity within themselves in order to achieve empathy in an authentic way.

There is a scale that is used to measure empathy to determine if the correct MI techniques are being used. It is called the Motivational Interview Treatment Integrity Scale. It measures “global empathy” as well as MIT “spirit,” and includes an “assessment of evocation” (i.e., eliciting a patient's own reasons for change), “collaboration” (actively partnering with the patient), and “autonomy” (helping the patient understand that change only comes from within themselves). There are six recognized physician/provider behaviors that positively or negatively affect the provider's MIT “spirit” score

- Closed Questions (negative effect; avoid using)
- Open Questions (positive effect)
- Simple Reflection—a signal of understanding (positive effect)
- Complex Reflection—a signal of understanding that adds meaning to their reflection (positive effect)
- MIT Consistent Behaviors—asking permission, affirming their intention, emphasizing their control (positive effect)
- MIT Inconsistent Behaviors—advising without permission, confronting, directing (negative effect; avoid using)

The patient with obesity is in a classic decisional conflict: they are aware at some level that their obesity is having a profound effect on their health and life [21]. They

will have tried many commercial methods of addressing it (buying books, dieting, joining a gym, going to a commercial weight loss program, etc.) but they really do not know much about why they are obese or what will really work.

The Development of Discrepancy

The discrepancy conundrum is that the patient with obesity does not fully understand the risks of obesity or the benefits of treatment. Once the motivational interviewing techniques are used to initially engage the patient, you need to go further and develop discrepancy within the patient using the same interviewing techniques to organize their thoughts. The development of discrepancy involves engaging the patient in exploring the pros and cons of his/her current level of obesity and discussing what action can be taken to affect change. In short, discrepancy involves developing awareness in the patient of the difference between their current state of health and their broader goals and values. This is the “active ingredient” of transformation [22].

After years of doctors appointments, many patients experience confrontation from their healthcare providers as an approach to coaxing behavior change. The confrontation approach is ineffective and is often born of the frustration a healthcare provider feels about a patient’s perceived lack of compliance and lack of results. Many providers feel a sense of accomplishment when they diagnose hypertension or diabetes and prescribe a medication. On subsequent visits, the patient often has normal blood pressure or blood sugar as a result of the treatment protocol. The management of obesity is less gratifying in the short run and frustration can lead to confrontation rather than the empathy required to facilitate long-term behavior change. Consistency of effort, the essence of successful obesity management, is necessary.

Instead of confronting the patient, developing a sense of discrepancy will, in turn, develop self-determination in the patient. Self-determination theory begins with external regulation (like being on a two week “induction” diet) where external controls (the prescribed menu and “rules”) are present and the process only works when those external controls are in place. The next step is introjected regulation, where a person puts pressure on himself/herself to exhibit certain behavior. This is very similar to what takes place when a patient adopts a set of rules (i.e., for the next few weeks I will be on a “maintenance” diet plan) and the patient then constantly deals with their compliance or noncompliance with rules they have set up for themselves. This creates an energy sink for the patient, causing constant conflict within them.

Most patients with obesity are either in external or introjected regulation. Ideally, the best place for a patient to be is in “integrated regulation,” when they become intrinsically motivated to achieve certain goals that are part of their core values. “Intrinsic motivation” is most often discussed in the context of psychological behavior change [23]. Under the traditional model of treating obesity, the focus is

on a psychological or emotional construct, not a physiological one. We should, however, be open to the idea that this model is incomplete. Intrinsic motivation can be viewed as incorporating an understanding of how the biology of obesity interacts with psychological/emotional motivation. MIT can help the patient manipulate their biology to achieve better health using consistent behavior to change physiology through epigenetic manipulation.

In regards to the current treatment of obesity, certain maxims are clear. First, in order to break through the decisional conflict of a patient struggling to overcome obesity, the patient must know their own burden of disease by getting consistent, reliable, objective feedback on their specific measurements of Weight Related Health Indicators for BMI, waist circumference, and body fat percent. Second, that information must be communicated to them on a consistent, unbiased, and sequential basis using a tool such as the WRC. Third, they need education about obesity as a biologic and physiologic response to the environment and they must be taught what treatment will work and what will not work. Fourth, the patient's expectations should be aligned with the realities of current therapeutic options. Fifth, successful treatment requires consistent follow-up and motivational/nonconfrontational support delivered with empathy. Simply asking about weight or talking generally about losing weight is not sufficient to engage patients in behavior change. It is necessary to know and use MIT in each encounter.

Implementing Specific Process for Chapter Two Recommendations

Implementing a philosophy of unbiased and effective empathy will require putting in place a specific process. The first step is a commitment on behalf of the leadership of the healthcare environment to establish a clinical philosophy of unbiased and a therapeutic environment of empathy and effective treatment for the patient with obesity.

For Staff and Colleagues

- Survey staff, colleagues and self using the Implicit Association Test and Fat Phobia Scale to reveal bias.
- Require sensitivity training for all staff that includes education on the biology of obesity.
- Train staff on the accurate assessment of the WRHI and provide the WRC to each patient in each visit. Decide on a process for implementation within your healthcare setting.
- Invest in teaching staff and colleagues MIT and Self-Determination Theory.

- Include questions in patient experience surveys regarding obesity bias and stigma.
- Create a culture of “no tolerance” for jokes or comments that stigmatize obesity.
- Walk the talk: require that office snack foods brought into the practice be healthy, and do not accept “food” donations from patients unless they are healthy.

For Patients

- Communicate to patients in each visit using the WRC based on their WRHI. It is critical to accurately verify the **measured** height and weight of a patient, not just take their word for it. Most patients think they are taller than they are (Table 2.2)—Example of use of the WRC).
- WRCs are color-coded to communicate risk based on BMI, Waist Circumference (≤ 40 in for men and ≤ 35 in for women), and Body Fat Percent (≤ 25 for men and ≤ 35 for women).
- Measuring all patients across the board will reduce bias by not singling anyone out, and will provide essential clinical information to the patient, the provider and the healthcare system. It will make the level of obesity “real” and create an opportunity for engagement and support.
- Invite and encourage patients with a higher risk (yellow, orange or red WRC) to make an appointment with a trained weight specialist to enable the patient and healthcare team to gain a deeper understanding of the patient’s personal clinical context (biology) of obesity, to assess related disease, and to develop a plan to

Table 2.2 Adult Weight Related Report Card based on Weight Related Health Indicators

		Range	Points	Score
BMI		18.5–24.9	0	
		25.0–29.9	1	1
		30.0–39.9	2	
		> 40	3	
Waist circumference	Male	≤40 in	0	
		≤40 in	1	1
	Female	≤35 in	0	
		≥35 in	1	
Body fat %	Male	≤25	0	
		≥25	1	1
	Female	≤35	0	
		≥35	1	
Health report card			Total Points	3

Total Points	Health Report Card
0	Green
1	Green
2	Yellow
3	Orange
4	Red
5	Red +

lower risk. This kind of comprehensive visit will be outlined in the therapeutic chapters of this book.

- Establish a unique section in the electronic health record (EHR) that includes the WRHI data and WRC in dashboard format for easy recovery and sequential monitoring by the team.

Physical Environment of the Workplace

Provide a physical environment that is complementary to the culture you have established. Ensure that the equipment in your office can accommodate the level of obesity you are seeing:

- Chairs in the waiting room (make them all big to avoid stigma)
- Calibrated scale that measures body weight and body fat percent to at least 600 lb
- Extra large gowns (patients who are healthy body weight will feel good in larger gowns as well)
- Blood pressure cuffs appropriately sized

Conclusion

Discrimination and obesity bias are widespread both in society and among healthcare workers. Stigma in the healthcare environment leads to inconsistent evaluation and management of obesity, discourages the patient from seeking timely care, and increases the cost of care. The value proposition is not met adequately in this type of treatment environment and diminishes the patient experience.

The myth that obesity is a personal choice and not a matter of biology is the single biggest fallacy driving physician attitudes and behavior. Chapters 3 and 4 demonstrate the misconceptions of this paradigm and lay to rest the foundation of blame that has been the cornerstone of poor and inconsistent treatment of obesity by the medical community. Consistency in the management of obesity is a requirement of the healthcare provider. Every patient should be objectively measured at every appointment. Their WRHI should be clinically reported as a part of their medical history and should be directly communicated via the WRC to the patient.

To engage patients in their own health care, MIT and Self-Determination Theory should be implemented in a ubiquitous way throughout the healthcare environment. In order to establish an unbiased culture and to ensure effective treatment of obesity, educating all health practitioners about the biology of obesity is also of paramount

importance. In addition, sensitivity testing and training must be ongoing to eliminate the explicit and implicit bias against obesity that may persist. Physically, the healthcare environment should reflect the enlightened culture of the practice in order to provide safe and optimally effective understanding and treatment.

References

1. Puhl RM, King KM. Weight discrimination and bullying. *Best Pract Res Clin Endocrinol Metab.* 2013;27:117–27.
2. Heuer CA, McClure KJ, Puhl RM. Obesity stigma in online news: a visual content analysis. *J Health Commun.* 2011;16:976–87.
3. Andreyeva T, Puhl RM, Brownell KD. Changes in perceived weight discrimination among Americans, 1995–1996 through 2004–2006. *Obesity.* 2008;16(5):1129–34.
4. Jay M, Kalet A, Ark R, McMacken M, Messito MJ, Richter R, Schlair S, Sherman, Zabar A, Gillespie C. Physicians' attitudes about obesity and their associations with competency and specialty: a cross-sectional Study. *BMC Health Serv Res.* 2009;9:106–17.
5. Sabin JA, Marini M, Nosek BA. Implicit and explicit anti-fat bias among a large sample of medical doctors by BMI, race/ethnicity and gender. *PLoS ONE.* 2012;7(11):e48448.
6. Foster GD, Wadden TA, Makris AP, Davidson D, Sanderson RS, Allison DB, Kessler A. Primary care Physician's attitudes about obesity and its treatment. *Obes Res.* 2003;11(10):1168–77.
7. Befort CA, Greiner KA, Hall S, Pulvers KM, Nollen NL, Charbonneau A, Kaur H, Ahluwalia JS. Weight-related perceptions among patients and physicians: how well do physicians judge patients' motivation to lose weight? *J Gen Intern Med.* 2006;21:1086–90.
8. Puhl RM, Heuer CA. The stigma of obesity: a review and update. *Obesity.* 2009;17:941–64.
9. Pantenburg B, Siorski C, Luppa M, Schomerus G, König H, Werner P, Riedel-Heller SG. Medical students attitudes towards overweight and obesity. *PLoS ONE.* 2012;7(11):e48113–8.
10. American Medical Association Rule 10.5.
11. Lynch HF. Discrimination at the doctor's office. *NEJM.* 2013;368(18):1668–70.
12. Schwartz MG, Chambliss HO, Brownell KD, et al. Weight bias among health professionals specializing in obesity. *Obes Res.* 2003;11:1033–77.
13. Wolfe BA. Presidential address-obesity discrimination: what can we do? *Surg Obes Relat Dis.* 2012;8:495–500.
14. Schvey NA, Puhl RM, Brownell KD. The stress of stigma: exploring the effect of weight stigma on cortisol reactivity. *Psychosom Med.* 2014;76:156–62.
15. Warner CH, Warner CM, Morganstein J, Appenzeller GN, Rachal J, Greiger T. Military family Physician attitudes toward treating obesity. *Mil Med.* 2008;173(10):978–84.
16. Must A, Anderson SE. Body mass index in children and adolescents: considerations for population = based applications. *Int J Obes.* 2006;30:590–4.
17. Ahmad NN, Kaplan LM. It is time for obesity medicine. *Virtual Mentor.* 2010;12(4):272–7.
18. Carroll W, Rhoades J. Agency for healthcare research and quality medical expenditure panel survey (MEPS) Statistical Brief #364: obesity in American: Estimates for the U.S. Civilian Noninstitutionalized Population Age 20 and older, 2009.
19. Barnes RD, Ivezaj V. A systematic review of motivational interviewing for weight loss among adults in primary care. *Obes Rev.* 2015;16:304–18.
20. Miller WR, Rollnick S. *Motivational interviewing helping people change* september. 3rd ed. New York: Guilford Press; 2012.
21. Markland D, Ryan RM, Tobin VJ, Rollnick S. Motivational interviewing and self-determination theory. *J Soc Clin Psychol.* 2005;24(6):811–31.

22. Miller WR. Motivational interviewing. III. On the ethics of motivational intervention. *Behav Cognit Psychother*. 1994;22:111–23.
23. Pollak KI, Alexander SC, Coffman CJ, Tulskey JA, Lyna P, Dolor RJ, James IE, Brouwer JN, Manusov JRE, Ostbye T. Physician communication techniques and weight loss in adults. *Am J Prev Med*. 2010;39(4):321–8.

Obesity

The Medical Practitioner's Essential Guide

Blackstone, R.P.

2016, XX, 337 p. 60 illus., 40 illus. in color., Softcover

ISBN: 978-3-319-39407-7