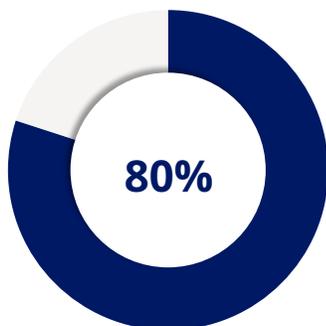




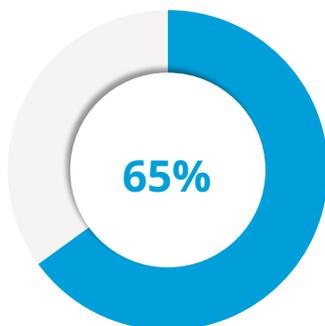


Perception of obesity

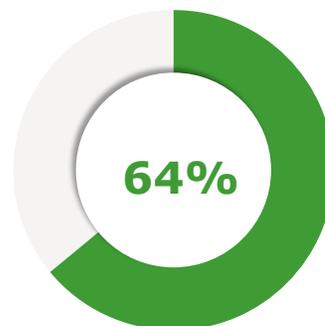
Obesity is a chronic disease (% agreement)



HCPs



PwO



Employers

HCP, healthcare professional; PwO, people with obesity.
1. Kaplan LM et al. *Obesity (Silver Spring)* 2018;26:61-69.



Obesity is recognized as a chronic disease



"American Medical Association recognizes obesity and overweight as a chronic medical condition (de facto disease state) and urgent public health problem...and work towards the recognition of obesity intervention as an essential medical service..."¹



"Obesity is a chronic relapsing health risk defined by excess body fat"²



"Obesity is a treatable disease that is a worldwide health concern associated with having an excess amount of body fat. It is caused by genetic and environmental factors and can be difficult to control through dieting alone..."³



"The Council of The Obesity Society recognizes that obesity is a complex condition with numerous causes, many of which are largely beyond an individual's control..."⁴



"Understanding obesity as a complex, chronic disease is essential for providing effective health care for overweight and obese patients..."⁵

1. AMA resolutions. <http://www.ama-assn.org/>. Accessed April 2020; 2. Food and Drug Administration. Guidance for Industry Developing Products for Weight Management. 2007. <https://www.fda.gov/media/71252/download>. Accessed April 2020; 3. Obesity Action Coalition. What is Obesity & Severe Obesity? 2020. <https://www.obesityaction.org/get-educated/understanding-your-weight-and-health/what-is-obesity/>. Accessed April 2020; 4. Council of the Obesity Society. *Obesity (Silver Spring)* 2008;16:1151; 5. Overweight and Obesity Expert Panel, National Heart Lung and Blood Institute (NHLBI). Managing Overweight and Obesity in Adults: Systematic evidence Review From the Obesity Expert Panel. 2013; pp. 7.



Along with HCPs, there are many authorities and professional organizations around the world that recognize obesity as a chronic disease. Here we have highlighted a few, which resonate the same message: obesity is a progressive, relapsing disease characterized by excess body fat, and there is an urgent need to address and prevent this global epidemic



However...

71% of PwO discussed weight with an HCP within the past **5 years**

Mean of 7 serious WL attempts before discussing a WL plan with an HCP

HCP, healthcare provider; PwO, people with obesity; WL, weight loss.
1. Kaplan LM et al. Obesity (Silver Spring) 2018;26:61–69.



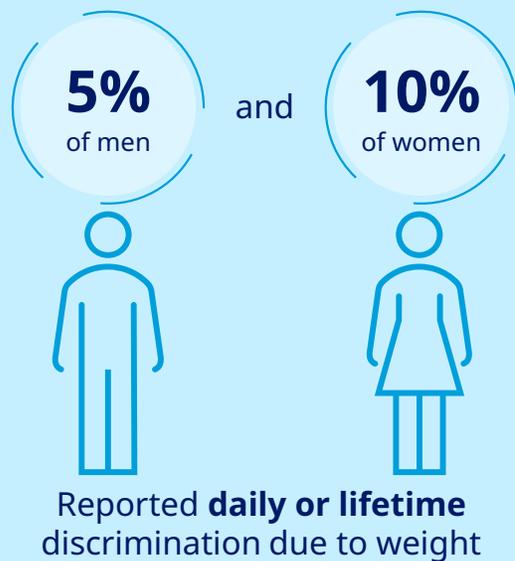
However, there is a gap in the management of obesity. From the ACTION study, 71% of PwO spoke with an HCP about their weight within the past 5 years. 38% of PwO discussed a WL plan with an HCP within the past 6 months. For many, these discussions came after numerous reported “serious WL efforts” in their adult lifetime (median = 3, mean = 7). Why is this? In our presentation today, we will discuss how weight bias and stigma can impact a patient’s decision to discuss weight management with their HCP.

Weight Bias

Weight bias ranks just below race, gender, and age as the fourth most common form of discrimination in the US

31%

of weight IAT respondents had strong automatic preference for people **without** obesity*



1. Puhl R et al. *Int J Obes* 2008;32:992–1000.

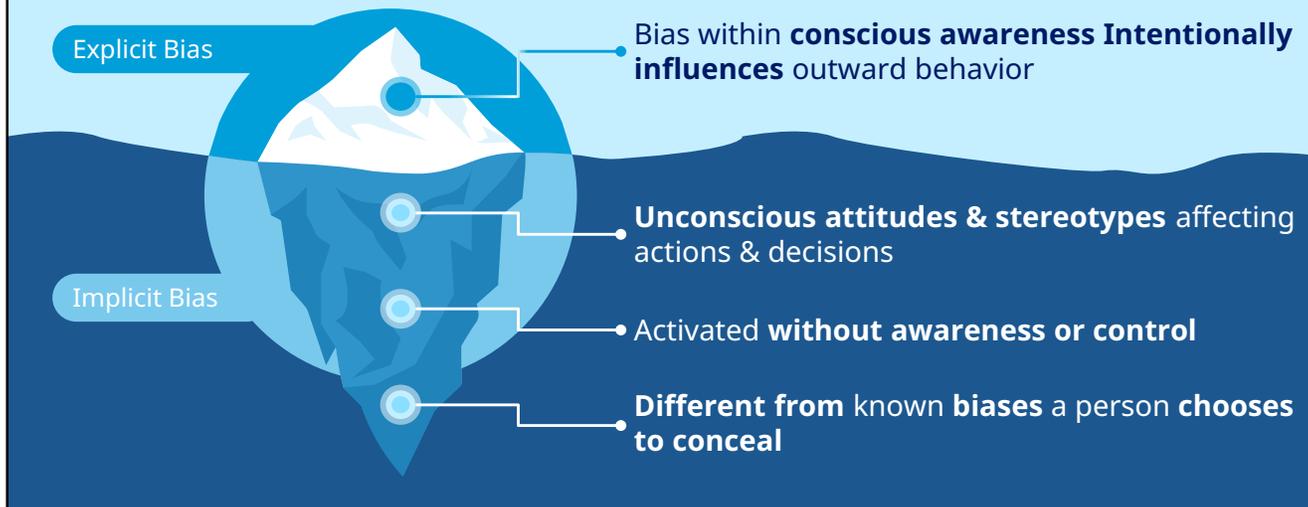


Data were from the National Survey of Midlife Development in the United States, a 1995–1996 community-based survey of English-speaking adults aged 25–74 ($N=2290$). Reported experiences of weight/height discrimination included a variety of institutional settings and interpersonal relationships. Multivariate regression analyses were used to predict weight/height discrimination controlling for sociodemographic characteristics and body weight status.

Compared to other forms of discrimination among US adults, weight/height discrimination ranked as the third most prevalent cause of perceived discrimination among women (after gender and age discrimination), and the fourth most prevalent form of discrimination among all adults (after gender, age and race discrimination) (Figure 1). In general, rates of self-reported discrimination were high in this sample with almost every second person reporting at least one occurrence of any type of discrimination (46%), particularly among women. Gender discrimination was the most prevalent type of discrimination reported due to particularly high rates reported by women (27%), exceeding by a margin other common causes of discrimination like race, age and weight/height.

On average, 10.3% of women reported daily or lifetime discrimination due to weight/height, while men were half as likely to report such experiences (4.9%, $P<0.01$)

Implicit¹ vs. explicit bias



1. Understanding Implicit Bias. Kirwan Institute for the Study of Race and Ethnicity. 2015. <http://kirwaninstitute.osu.edu/research/understanding-implicit-bias/>. Accessed May 2020.



Implicit bias:

- Refers to the attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner (also known as implicit social cognition)
- Activated involuntarily and without an individual's awareness or intentional control
- Resides deep in the subconscious
- Not accessible through introspection
- Different from known biases that individuals may choose to conceal for the purposes of social and/or political correctness

Implicit vs. explicit bias. Forms of bias are categorized as either implicit or explicit. Implicit bias is automatically activated and tends to be more unconscious, influencing individual behavior without clear awareness. The most common way to measure implicit bias is by using an Implicit Association Task (IAT), in which images and words appear on a screen and strength of association is measured by response latency. Project Implicit¹⁰ offers different versions of IATs, including "Weight ('Fat-Thin' IAT)". This IAT would conclude the test taker displayed an automatic preference for people without obesity over those with obesity if he or she responded more quickly when "bad" words like "angry" and "horrible" and images of individuals with obesity were assigned to the same response key than the reverse (e.g., bad words and images of people without obesity assigned to same key). Data collected from the Project Implicit Weight IAT reveal a majority automatic preference for "thin" people relative to "fat" people

Explicit bias is within conscious awareness and influences outward behavior in an intentional manner. Assessment of explicit bias can be completed using self-report surveys.

1. Understanding Implicit Bias. Kirwan Institute for the Study of Race and Ethnicity. 2015.

<http://kirwaninstitute.osu.edu/research/understanding-implicit-bias/>. Accessed May 2020.

2. Weight IAT test. Project Implicit®. <https://implicit.harvard.edu/implicit/selectatest.html>. Accessed May 2020.

HCP **weight bias** impacts care



HCPs view PwO as less adherent¹

- Physicians perceived medication adherence by patients with BMI ≥ 40 kg/m² would be **0.33-fold** lower than with patients with normal weight

BMI, body mass index; HCP, healthcare professional; PwO, people with obesity.
1. Huizinga MM et al. *Obesity (Silver Spring)* 2010;18:1932-37.



Less adherent: physician-reported perception of medication adherence by BMI category. Analysis was adjusted for patient clustering by physician. The prevalence ratio of the patient being perceived as adherent by their physician tended to be lower for each class of obesity when compared to normal weight patients¹

1. Huizinga MM et al. Disparity in physician perception of patients' adherence to medications by obesity status. *Obesity (Silver Spring)* 2010;18:1932-1937.

HCP **weight bias** impacts care



HCPs provide less time in care with PwO¹

- Physicians reported spending close to **9 minutes fewer** in appointments with people with obesity than with people with average weight

*post-hoc comparisons of P <0.05.

BMI, body mass index; HCP, healthcare professional; PwO, people with obesity.

1. Hebl MR & Xu J. *Int J Obes* 2001;25:1246-52.



122 primary care physicians participated in a survey of medical procedures and patient follow-up questions. Physicians reported spending close to 9 minutes fewer in appointments with people with obesity than with average weight people

1. Hebl MR & Xu J. Weighing the care: physicians' reactions to the size of a patient. *Int J Obes* 2001;25:1246-1252.

HCP weight bias impacts care



68%

women with BMI >55 kg/m² delayed care due to bias even with insurance coverage¹

~60%

increased risk of mortality associated with weight-based discrimination²

PwO reasons for avoiding care:



36% Uncomfortable with HCP

46% Unsolicited advice

36% Provider negative attitude

BMI, body mass index; HCP, healthcare professional; PwO, people with obesity.

1. Amy NK et al. *Int J Obes* 2006;30:147–155; 2. Sutin AR et al. *Psychol Sci* 2015;26:1803–1811.



A survey of 498 White and African American women revealed that women in higher BMI categories reformed affirmatively to the question “have you ever delayed seeking health care or cancer-screening tests because of your weight” and “has your weight been a barrier to getting appropriate health care”³

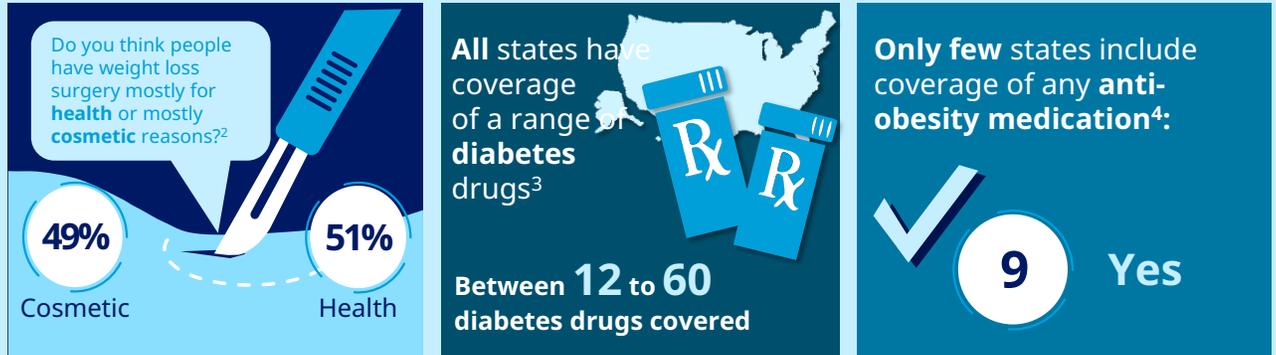
To investigate the factors that may contribute to lower rates of screening for gynecological cancer in women with overweight and obesity. Survey including questions on patients’ experiences and potential and actual barriers that cause delay in seeking treatment. A purposeful sample of 498 white and African American women with BMIs ranging from 25 to over 55. Stepwise multiple regression analysis was used to examine whether BMI was associated with weight-related barriers. Several issues impacted on patients’ willingness to obtain care: disrespectful treatment (36%), embarrassment of being weightied (35%), negative attitudes of providers (36%), unsolicited advice about weight loss (46%) and equipment failures (46%). Findings indicated that those women who delayed seeking care

In women with BMI>55 kg/m², 68% reported that they delayed seeking health care because of their weight, and 83% reported that their weight was a barrier to getting appropriate health care. These figures should be viewed in light of the fact that greater than 90% of the women had health insurance (Table 1). Thus, the reported delay was not a result of lack of available health care. The responses to the two questions in Figure 1 were not related to the women’s level of education, insurance coverage, or type of health care (private, HMO, or health clinic)

1. Amy NK et al. Barriers to routine gynecological cancer screening for White and African-American obese women. *Int J Obes*. 2006;30;147-155
2. Sutin AR et al. Weight Discrimination and Risk of Mortality. *Psychol Sci* 2015;26:1803–1811

Weight bias can impact coverage

The assumption that body weight is entirely controllable by lifestyle choices may affect coverage for obesity treatment¹

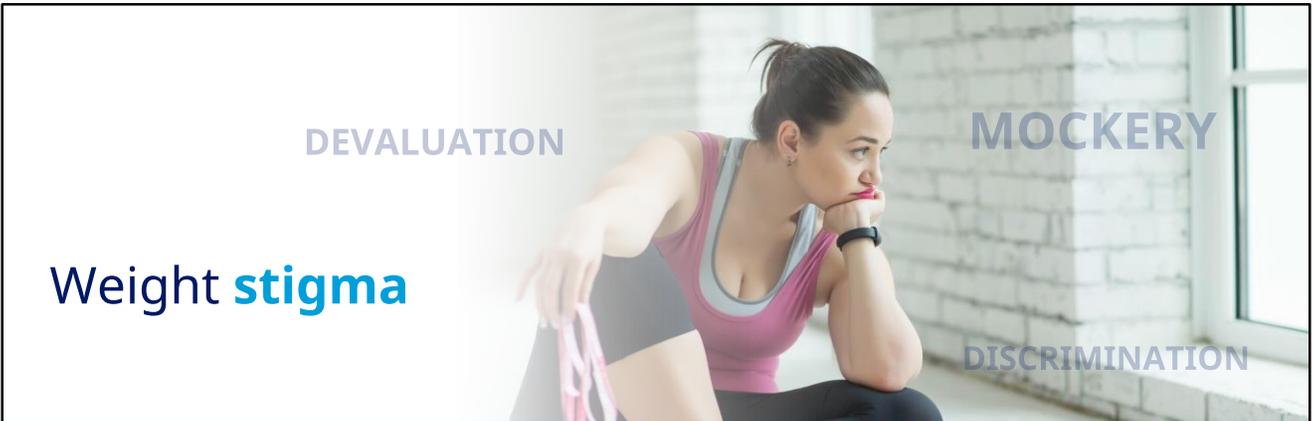


1. Rubino F et al. *Nat Med* 2020;26:485–497; 2. Dolan P et al. *JAMA Surg* 2019;154:264–266;
 3. Diabetes Pharmaceuticals State Mandates. National Conference of State Legislatures (NCSL). 2016. <https://www.ncsl.org/research/health/diabetes-pharmaceuticals-state-mandates.aspx>. Accessed May 2020;
 4. Gomez G & Stanford FC. *Int J Obes (Lond)* 2018;42:495–500.



- Widespread assumption that body weight is entirely controllable by lifestyle choices and that self-directed efforts can reverse even severe forms of obesity or T2D may be the reason for low level of public support for the coverage of anti-obesity interventions beyond diet and exercise¹
- Many public and private health insurers either do not provide coverage or have substantive limitations in the coverage for metabolic surgery¹
 - Need to fulfil a number of criteria to be eligible
 - Many other chronic diseases have coverage and are not subject to the same restrictions
- In a national survey, a large percentage of the population has negative attitudes toward weight loss surgery. The high prevalence of these attitudes potentially creates a difficult social environment for patients who opt for weight loss surgery²
 - 468 respondents (49.4%) thought that most people had weight loss surgery for cosmetic reasons and 371 (39.1%) thought that people who had weight loss surgery chose the “easy way out”
- 30 states and D.C. had at least one of the two surveyed plans listing 50 or more brand choices³
- All states and D.C. show varying coverage of selected brand name drugs, offering anywhere from 12 to 60 diabetes drugs³
- All states and D.C. provide coverage for at least 11 or more of selected generic drugs³
- A study investigating FDA-approved medications for obesity within Medicare, Medicaid, and State Marketplace health plans discovered only 9 states had at least one silver plan that included some type of coverage for obesity medications. 25 stated no and only 34 states were evaluated in the study⁴
 - The covered medications were generally the older FDA-approved medications for the treatment of obesity. The newer FDA-approved obesity medications tend to be covered as tier 3 medications

1. Rubino F et al. Joint international consensus statement for ending stigma of obesity. *Nat Med* 2020;26:485–497
2. Dolan P et al. Assessment of Public Attitudes Toward Weight Loss Surgery in the United States. *JAMA Surg* 2019;154:264–266
3. Diabetes Pharmaceuticals State Mandates. National Conference of State Legislatures (NCSL). 2016. <https://www.ncsl.org/research/health/diabetes-pharmaceuticals-state-mandates.aspx>. Accessed May 2020
4. Gomez G, Stanford FC. US health policy and prescription drug coverage of FDA-approved medications for the treatment of obesity. *Int J Obes (Lond)* 2018;42:495–500



DEVALUATION

MOCKERY

Weight **stigma**

DISCRIMINATION

“Describing individuals as **obese** as opposed to **having obesity** could have negative impact on how people view them... People-first language has been widely adopted for most chronic diseases and disabilities, **but not obesity³**”

1. Pearl L et al. *Obesity* 2017;25:317–322; 2. Phelan SM et al. *Obesity reviews* 2015;16:319–326;
 3. People-First Language for Obesity. Obesity Action Coalition. 2020. <https://4617c1smqldcqsat27z78x17-wpengine.netdna-ssl.com/wp-content/uploads/People-First.pdf>. Accessed May 2020.



- Weight stigma is the public derogation, devaluation, and discrimination faced by individuals with obesity¹
 - Stigma describes physical characteristics or character traits that mark the bearer as having lower social value²
 - Enacted stigma – behaviours that emanate from negative attitudes about a stigmatized group
 - Can be broken into explicit or implicit negative attitudes
 - Explicit: conscious and reflect a person’s opinions or beliefs about a group
 - Implicit: automatic and often occur outside of awareness; usually contradicts explicitly held beliefs
1. Pearl L et al. Association Between Weight Bias Internalization and Metabolic Syndrome Among Treatment-Seeking Individuals with Obesity. *Obesity* 2017;25:317–322
 2. Phelan SM et al. Impact of weight bias and stigma on quality of care and outcomes for patients with obesity. *Obesity reviews* 2015;16:319–326
 3. People-First Language for Obesity. Obesity Action Coalition. 2020. <https://4617c1smqldcqsat27z78x17-wpengine.netdna-ssl.com/wp-content/uploads/People-First.pdf>. Accessed May 2020

Patients who experience weight stigma have both behavioral and physiological changes

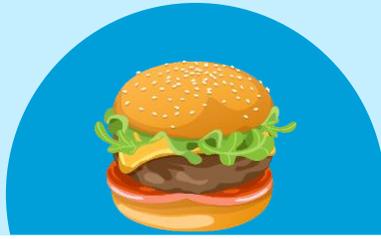
2.4× more likely to have a major depressive episode³

1.5× higher distress⁴ over body image^{1,2}



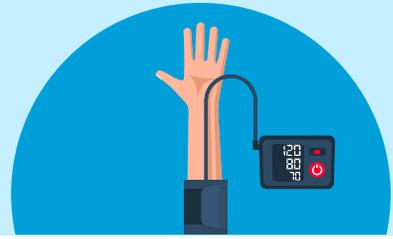
3.4× more calories consumed⁵

1.4× lower score on self-efficacy scale* for dietary control⁶



2.3× more likely to avoid exercise⁸

1.4× increased BP⁷



*Self-efficacy scale assessed confidence on the following questions: Could you control what you eat; avoid eating unhealthy food that you like; avoid unhealthy foods every day; stick to your diet even when you are hungry; and avoid giving in to temptation to break a diet if offered tempting foods. BP, blood pressure.
1. Puhl M et al. *Clin Diabetes* 2016;34:44–50; 2. Phelan SM et al. *Obesity reviews* 2015;16:319–326; 3. Hatzienbuehler ML et al. *Obesity (Silver Spring)* 2009;17:2033–2039; 4. Friedman KE et al. *Obesity Research* 2005;13:907–916; 5. Schvey NA et al. *Obesity* 2011;19:1957–62; 6. Major B et al. *J Exp Soc Psychol* 2014;51:74–80; 7. Major B et al. *Social Psychological and Personality Science* 2012;3:651–658; 8. Vartanian LR & Novak SA. *Obesity* 2011;19:757–762.



Impact

- Weight stigma can lead to^{1,2}:
 - Stress, binge eating, increase caloric consumption, less physical activity, poorer treatment adherence, less trust of health providers
 - Increased risk for depression, anxiety, low self-esteem, poor body image
- Participants' mean level of body image distress (mean = 122.7; SD = 30.9) was higher than the mean reported for community samples (mean = 81.5, SD = 28.4) and only slightly lower than the mean reported for bulimia nervosa patients (mean = 136.9, SD = 22.5)⁴
- When exposed to [weight-stigmatizing](#) videos, women with overweight **consumed 3.4 more calories** compared to women with overweight exposed to neutral videos⁵
- Participants indicated how confident they were (from 0 = not confident at all to 100 = very confident) that they could: control what you eat; avoid eating unhealthy food that you like; avoid unhealthy foods every day; stick to your diet even when you are hungry; and avoid giving in to the temptation to break a diet if offered tempting foods. Responses were averaged and combined into a single measure of self-efficacy
 - Perceived weight was significantly and negatively related to self-efficacy for dietary control ($\beta = -.50, p = .001$), in women that were exposed to weight-stigmatizing news articles. Among women who were not exposed to weight-stigmatizing articles, perceived weight was unrelated to self efficacy ($\beta = .15, p = .28$)⁶
- When exposed to implicit weight [stigma](#), women with high BMI who believed their weight would be visible to evaluators had 1.38× increased blood pressure, compared to women with BMI who believed their weight was not visible⁷
- For individuals high in anti-fat attitudes, experiences with weight stigma were positively related to avoidance of exercise ($t = 6.01, P < 0.001$). For individuals low in anti-fat attitudes, there was also a positive association between weight stigma and avoidance of exercise ($t = 2.80, P = 0.006$), but the magnitude of this association was smaller. For individuals high in internalization, experiences with weight stigma were positively related to avoidance of exercise ($t = 6.24, P < 0.001$). For individuals low in internalization, in contrast, experiences with weight stigma were not related to avoidance of exercise⁸
 - Likelihood was calculated using Figure 1 from the publication. Avoidance of exercise value reported on slide uses the high anti-fat attitudes chart (Figure 1A)

1. Puhl M et al. Overcoming Weight Bias in the Management of Patients With Diabetes and Obesity. *Clin Diabetes* 2016;34:44–50; 2. Phelan SM et al. Impact of weight bias and stigma on quality of care and outcomes for patients with obesity. *Obesity reviews* 2015;16:319–326; 3. Hatzienbuehler ML et al. Associations Between Perceived Weight Discrimination and the Prevalence of Psychiatric Disorders in the General Population. *Obesity (Silver Spring)* 2009;17:2033–2039; 4. Friedman KE et al. Weight Stigmatization and Ideological Beliefs: Relation to Psychological Functioning in Obese Adults. *Obesity Research* 2005;13:907–916; 5. Schvey NA et al. The impact of weight stigma on caloric consumption. *Obesity* 2011;19:1957–62; 6. Major B et al. The ironic effects of weight stigma. *J Exp Soc Psychol* 2014;51:74–80; 7. Major B et al. The Psychological Weight of Weight Stigma. *Social Psychological and Personality Science* 2012;3:651–658; 8. Vartanian LR & Novak SA. Internalized Societal Attitudes Moderate the Impact of Weight Stigma on Avoidance of Exercise. *Obesity* 2011;19:757–762

Weight **stigma** impacts quality of care:



Worse patient outcomes when HCPs provide less patient-centred care¹

- **20.1%** of patients achieved **≥10%** weight loss if they **did not perceive judgment** by their HCP, compared to **13.5%** who perceived judgment²

HCP, healthcare professional.

1. Puhl M et al. *Clin Diabetes* 2016;34:44–50; 2. Gudzone KA et al. *Prev Med* 2014;62:103–107.



Impact

- Providers have been shown to use less patient-centered language with patients they perceive as nonadherent¹
 - Expectation that patients will not comply with advice to lose weight may reduce the quality of counseling
 - Strong evidence that less patient-centered care predicts lower patient adherence, less patient-provider trust, and worse patient outcomes
 - Individuals with obesity were more successful in losing weight when their physicians did not come across as judgmental when discussing weight
 - **20.1%** of individuals achieved **≥10%** weight loss when their physicians did not come across as judgmental when discussing weight, compared to **13.5%** of individuals achieving successful weight loss when they did perceive physician judgement²
1. Puhl M et al. Overcoming Weight Bias in the Management of Patients With Diabetes and Obesity. *Clin Diabetes* 2016;34:44–50
 2. Gudzone KA et al. Perceived judgment about weight can negatively influence weight loss: a cross-sectional study of overweight and obese patients. *Prev Med* 2014;62:103–107.

Weight **stigma** impacts economic factors:



Workplace
discrimination¹



Research funding¹

1. Rubino F et al. *Nat Med* 2020;26:485–497.



The impacts of weight stigma also go beyond interactions with a healthcare provider and a patient. Weight stigma also has financial and economic consequences.

Weight **stigma** impacts economic factors:



Workplace discrimination¹



Women with overweight or obesity received hourly wages that were \$3.40 and \$8.10 **lower** than women with normal weight, respectively²



58% of hiring managers had a slight or strong preference for individuals with normal weight³

PwO, people with obesity.

1. Rubino F et al. *Nat Med* 2020;26:485–497; 2. Occupational characteristics and the obesity wage penalty. Vanderbilt University Law School. 2015. <https://ssrn.com/abstract=2379575>. Accessed May 2020; 3. Agerström J & Rooth DO. *J Appl Psychol* 2011;96:790–805.



Individuals with obesity have reported receiving lower starting salaries than thinner employees. They also can be ranked as less qualified and work longer hours. Persons with obesity are also less likely to be invited for an interview. If they are employed, however, people with obesity are perceived to be less successful compared with their thinner peers.¹

Women with obesity are less likely to be hired and a study reported that women with overweight are more likely to work in lower-paying jobs and make less money compared with women who are average-sized and all men²

Real hourly wages from 2008²

- Normal weight = \$23.528
- Overweight = \$20.100
- Obesity (labelled as Obese in the publication) = \$18.284
- Severe obesity (labelled as morbidly obese in the publication) = \$15.405

1. Rubino F et al. Joint international consensus statement for ending stigma of obesity. *Nat Med* 2020;26:485–497
2. Shinall JB. Occupational characteristics and the obesity wage penalty. Vanderbilt University Law School. 2015. <https://ssrn.com/abstract=2379575>. Accessed May 2020
3. Agerström J, Rooth DO. The role of automatic obesity stereotypes in real hiring discrimination. *J Appl Psychol* 2011;96:790–805

Weight **stigma** impacts economic factors:



Research funding

- ▶ Funding for obesity and diabetes is increasing, but still lags behind other disease areas^{1,2}
- ▶ NIH projected budget for **2020**²:
 - Obesity = \$1.17B
 - Diabetes = \$1.18B
 - Cancer = \$7.12B
 - Cardiovascular = \$2.5B
 - Genetics = \$10.5B

B, billion; M, million; NIH, National Institutes of Health.

1. Rubino F et al. *Nat Med* 2020;26:485–497;

2. NIH Categorical Spending. NIH. 2020. https://report.nih.gov/categorical_spending.aspx. Accessed May 2020.



- Research into obesity is underfunded compared with other diseases, relative to its burden and costs on society
- US National Institutes of Health's projected budgets for cancer, HIV/AIDS, and digestive diseases are 5–10 times greater than the budget for obesity, despite the latter affecting substantially more Americans
- Projected budget for obesity is \$1.17 billion²

1. Rubino F et al. Joint international consensus statement for ending stigma of obesity. *Nat Med* 2020;26:485–497
2. NIH Categorical Spending. NIH. 2020. https://report.nih.gov/categorical_spending.aspx. Accessed May 2020.

Obesity budget

2018- 1.055 B

2019- 1.109 B

2020- 1.173 B

Diabetes budget

2018- 1.039 B

2019- 1.099 B

2020- 1.179 B

Overall **impact** and **burden** of obesity:



Direct and indirect economic burden

Economic burden of obesity¹:

- \$480 billion direct costs
- \$1.24 trillion indirect costs
- ▶ Direct cost of obesity is **2×** greater than diabetes, and **480×** greater than cervical cancer^{2,3}
- ▶ Indirect cost of obesity is **13×** greater than diabetes and **512×** greater than cervical cancer^{2,3}

1. Ramasamy A et al. *JOEM* 2019;61:877–886. 2. American Diabetes Association. *Diabetes care* 2018;41:917–928. 3. Nwankwo C et al. *J Natl Compr Canc Ne* 2019;3.5:HSR19-102-HSR19-102.



- People with obesity have higher healthcare resource utilization (HRU) rates than individuals with normal BMI, leading to considerable excess healthcare costs
- Obesity is also associated with substantial indirect costs, such as those related to disability, workers' compensation, absenteeism (absence from work, such as sick leave), and presenteeism (reduction in productivity while at work)
- According to a report in 2016, obesity/overweight and its associated chronic diseases were estimated to account for more than \$480 billion in direct healthcare costs and \$1.24 trillion in indirect work loss costs in the US

1. Ramasamy A et al. Direct and Indirect Cost of Obesity Among the Privately Insured in the United States. *JOEM* 2019;61:877–886.

Direct and Indirect Costs of Diabetes²:

Indirect costs include:

- increased absenteeism (\$3.3 billion),
- reduced productivity while at work (\$26.9 billion) for the employed population,
- reduced productivity for those not in the labor force (\$2.3 billion),
- inability to work as a result of disease-related disability (\$37.5 billion), and
- lost productive capacity due to early mortality (\$19.9 billion)

Direct costs: \$237 billion in direct medical costs and \$90 billion in reduced productivity.

2. American Diabetes Association. Economic Costs of Diabetes in the U.S. in 2017. *Diabetes Care*. 2018;41(5):917-928. doi:10.2337/dci18-0007

Cervical Cancer³

Direct costs: \$1,087,008,804

Indirect costs: \$2,208,080,832

3. HSR19-102: Direct and Indirect Economic Burden of Cervical Cancer (CxCa) in the United States in 2015: A Mixed-Methods Analysis

Strategies to mitigate weight bias in the healthcare environment

Avoid stigmatizing or blaming words



Use “patient-first” language & be mindful of your approach

Implement sensitivity training & check materials for language & imagery

Patients with obesity, patients affected by obesity...

Could we talk about your weight today?

Increase obesity education in medical schools²



1. Still C. *Bariatric Times* 2018;15:3; 2. Kushner RF et al. *Obesity* 2019;27:1063–1067.



Avoid stigmatizing or blaming words. Avoid using words that are perceived negatively when talking to patients. Replace negative words such as “obese,” “morbidly obese,” or “fat” with terms like “unhealthy weight” or “high body mass index.”
Use “patient-first” language. When talking about obesity, use “patient-first” language, such as “patients with obesity” or “patients affected by obesity.” Patient-first language allows the patient to be distinguished from their weight, whereas “obese” encapsulates the patient and his or her weight all in one. People are not their disease, and we must remember that when discussing obesity.

Be mindful of your approach when discussing weight. The following questions are all constructive ways you can discuss weight with your patients:

“Could we talk about your weight today?”

“How do you feel about your weight?”

“What words would you like us to use when we talk about weight?”

Implement sensitivity training. If not already offered, annual sensitivity training might be implemented for staff working with bariatric patients, including those outside of the bariatric program. Such training might include an education session on obesity as a multifactorial disease and/or a presentation by a patient volunteer sharing their weight loss experience, good or bad.

Examine your program’s education and marketing material for appropriate language and imagery. You can view <https://www.obesityaction.org/image-gallery/> and <http://www.uconnruddcenter.org/image-library> for more information.

Educate. Inform. Be the example. Take every opportunity to use patient-first language and educate colleagues on treating patients with obesity. Discuss obesity as a disease, review the treatment options available, and focus on humanizing individuals affected by obesity during case presentations.

Speak up. Do not tolerate or accept weight bias in any form.

1. Still C. More than a Word—Putting Patients First. *Bariatric Times*. 2018; 15(2):3.
2. Kushner RF et al. Development of Obesity Competencies for Medical Education: A Report from the Obesity Medicine Education Collaborative. *Obesity* 2019;27:1063–1067

Resources

Obesity Action Coalition
<https://www.obesityaction.org/>

Obesity Medicine Association
<https://obesitymedicine.org/>

The Obesity Society
<https://www.obesity.org/>

Implicit Bias Tests
<https://implicit.harvard.edu/implicit/selectatest.html>

Obesity Medicine Education Collaborative
<https://obesitymedicine.org/omec/>

