Episode 9 - Weight Stigma & Weight Inclusive Medical Care

Citation: Chiu C, Bridge L. "Weight Stigma and Weight Inclusive Medical Care" Everyday Medicine Podcast, Episode 9, https://open.spotify.com/episode/2IPw2iF0Nb5oJmP15VPp4O. Publishing Date December 12, 2024.

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Sponsor: The Ohio Chapter of The American College of Physicians

Episode Summary:
Dr. Christopher Chiu interviews Dr. Laura Bridge, a general internal medicine physician at Ohio State University with expertise in eating disorders, about weight stigma in healthcare and weight-inclusive medical care. They discuss the impact of weight stigma on patient health outcomes, the relationship between weight and health, and practical approaches to providing weight-inclusive care in primary care settings.

Key Takeaways:

1. Understanding Weight Stigma:
    - Form of discrimination based on actual or perceived body weight
    - Can be both implicit and explicit bias
    - Often involves assumptions about personal responsibility for weight
    - Leads to internalized shame and decreased self-efficacy
    - One of the most common sources is healthcare providers (60% report experiencing it)
2. Health Impacts of Weight Stigma:
    - Acts as chronic psychosocial stressor
    - Increases inflammation markers (cortisol, CRP)
    - Raises risk of cardiovascular disease
    - Associated with higher rates of:
        - Hypertension
        - Dyslipidemia
        - Anxiety and depression
        - Substance abuse
        - Suicide risk
3. Weight and Health Relationships:
    - Correlation doesn't equal causation
    - Health and weight are not synonymous
    - Comorbidities more accurately predict health outcomes than BMI

- Some studies show better outcomes in slightly higher weight categories
- Focus should be on treating/preventing comorbidities rather than weight

4. Weight Cycling:
    - Known as "yo-yo dieting"
    - Creates physiologic stress and pro-inflammatory state
    - Body has natural weight set point regulated by hypothalamus
    - Repeated weight loss/gain can increase:
        - Cardiometabolic risk
        - Insulin sensitivity
        - Type 2 diabetes risk
5. Clinical Practice Recommendations:
    - Ask permission before discussing weight
    - Make weighing optional for patients
    - Focus on health behaviors rather than weight
    - Emphasize patient strengths and agency
    - Use weight-neutral language
    - Consider hiding weight from after-visit summaries
    - Connect patients with weight-neutral dietitians
6. Weight-Inclusive Care Approach:
    - Focus on health rather than weight
    - Patient-centered goal setting
    - Emphasis on shared decision-making
    - Recognition that health means different things to different people
    - Regular preventive care regardless of weight
7. Healthcare Provider Responsibilities:
    - Examine personal biases
    - Ensure equal time and attention to all patients
    - Offer same treatment options regardless of size
    - Use empathetic approach
    - Consider impact of weight stigma on preventive care
    - Train office staff in weight-inclusive care
8. Practical Implementation:
    - Focus on measurable health outcomes
    - Discuss specific health behaviors
    - Address sleep, regular eating patterns
    - Consider food quality over quantity
    - Address other health behaviors (smoking, alcohol)
    - Create safe, welcoming environment for all patients

Transcript:
This transcript has been edited for clarity

[00:00:00] **Christopher:** Welcome to Everyday Medicine. I'm Christopher Chiu. This is a podcast from the Division of General Internal Medicine at The Ohio State University, where I'm the Director of Education for the Division. This podcast is focused on primary care and aims to provide current information to medical professionals from experts in Ohio.

[00:00:24] We're also graciously sponsored by collaboration with the Ohio Chapter of the American College of Physicians.

[00:00:29] So today I have an amazing expert and one of my good friends, Dr. Laura Bridge. Hey, Laura, how are you doing?

[00:00:39] **Laura:** I'm fine, Chris. How are you?

[00:00:41] **Christopher:** Do you want to introduce yourself to our audience a little bit?

[00:00:43] **Laura:** Sure. I'm a general internal medicine physician. I practice outpatient primary care at the Ohio State University. And I have a particular area of interest in eating disorders. So I practice general adult primary care, but I have a sort of niche practice that focuses on eating disorders.

[00:01:00] **Christopher:** Excellent. And actually, the reason why I have you on is because you had a couple of really big talks that I thought were great. You gave one of our grand rounds for the Department of Internal Medicine. Was that last year?

[00:01:11] **Laura:** Last fall, I think. Yes.

[00:01:13] **Christopher:** And then within a short period of time, you also did a talk for the Ohio chapter of ACP, which is one of our sponsors for the podcast as well.

[00:01:21] Didn't you?

[00:01:22] **Laura:** I presented the last two years. So I presented on eating disorders and then this past fall I presented on weight stigma.

[00:01:30] **Christopher:** Excellent. And today we're really going to dive a little bit more about weight stigma and how to talk to patients about weight. I think we had talked because recently I did an episode about obesity medicine with some of our obesity experts here and I think they're obviously adjacent to each other and I think they can work hand in hand if done correctly.

[00:01:49] I thought it was great to have you on to talk a little bit more about this.

[00:01:52] **Laura:** Yeah, I think whenever we talk about weight and obesity, everybody's goal, we all went into medicine for the same reason. We want to do the best for our patients and take care of our patients and promote health. And we just have slightly different perspectives on how to get there.

[00:02:07] **Christopher:** What exactly is weight stigma and why does it matter?

[00:02:09] **Laura:** So when we talk about weight stigma, what we're talking about is a form of discrimination. And it's also sometimes called weight bias.

[00:02:16] It's a form of discrimination or stereotyping, and it's based on either a person's actual BMI or body weight or the perception of their body weight based on what you're seeing in terms of their size and their body shape and appearance. It can be either implicit or explicit, and it's often both.

[00:02:33] So there's a lot of talk about implicit bias, so it's a form of implicit bias, but it can also be explicit. And it often also involves a lot of assumptions that individuals are responsible for their body weight, size and shape. And for an individual who may be living in a larger body, it can become internalized.

[00:02:54] So a lot of self blame can lead to decreased self efficacy. And there can be a lot of downstream consequences in healthcare and beyond healthcare. Because of weight bias and weight stigma.

[00:03:05] **Christopher:** Now as a primary care physician, you know, we've obviously been taught throughout the years that we should be talking about weight specifically to patients. Is there a reason why we've been telling people that they have to be a certain weight? Was there some sort of correlation that we've previously thought but that may not necessarily be as strong as we actually think.

[00:03:24] **Laura:** That's a very interesting question. Is there a reason why we've been telling people or why we've been assuming that we need to talk to people about their weight? If you think about the history of this obesity epidemic sort of scare that we've had, I think it's very multifaceted.

[00:03:44] I don't think you could point to one reason why it has gotten to the point that it has and why medicine has taken the approach that we have, but I do think that there's a difference between correlation and causation, and I don't think that the evidence for causation is as clear as we were all trained to believe that it was. So while there are correlates, the evidence for causation between health outcomes and BMI or weight is not as straightforward. It is so multifaceted and multifactorial. And there is actually some evidence that people who are moderately overweight may have better health outcomes than people who are what we would call normal weight or in the normal BMI category or slightly underweight certainly. So it gets very murky very quickly.

[00:04:35] **Christopher:** I understand. So basically, being healthy doesn't mean thin and being obese doesn't mean you always have comorbidities. There's definitely just because there's maybe some correlations that may be there that we've seen throughout the years may not necessarily mean a causal thing. And like you said, I believe there's some more, I think it's in the geriatric world. There were some studies looking at better health outcomes for those who are even slightly considered overweight by BMI.

[00:05:00] **Laura:** Correct? Yes. I think it was that like class one obesity had better health outcomes and better mortality than.

[00:05:07] Sort of the normal BMI category, but that was shown in some studies. And then again, you have conflicting results. So it's hard to come to a conclusion when one study contradicts another. I think what's happened is we've conflated the terms health and weight. And so we've made those synonymous when they really are not.

[00:05:27] You used a word that I really like to focus on, which is comorbidities. And so comorbidities. more accurately predict somebody's health outcomes and their health status than their BMI or their weight. So when I'm taking care of patients in primary care and when patients come to me very concerned about their health, that's really what we focus on is treating comorbidities and preventing comorbidities.

[00:05:49] **Christopher:** Can you tell me a little more about what types of effects that happen to these individuals who are witnessing, experiencing these weight stigma, especially even from their health care providers?

[00:05:59] **Laura:** So this is a very important topic in health care, not just primary care, but all health care. When you talk to people who have experienced weight stigma, the two most common sources of weight stigma are family members and health care providers and among people who have experienced weight stigma, they report 60 percent of them report having experienced weight stigma from health care providers.

[00:06:21] So it's very important that we as health care providers know that. Especially, check our implicit biases. It's a form of chronic psychosocial stress. So just like poverty and the other social determinants of health care that we think about. It can lead to increased chronic inflammation.

[00:06:43] It increases the risks of cardiovascular disease. There's an increased risk of mortality. So you're looking at increased risks of real significant detrimental health outcomes for people. Hypertension, dyslipidemia. You can measure Markers of chronic inflammation. So when you control for BMI, you have patients at the same BMI who report higher levels of experiencing weight stigma, they have higher levels of cortisol, CRP and other markers of oxidative stress.

[00:07:14] They have higher rates of hypertension, higher rates of dyslipidemia and higher all-cause mortality.

[00:07:19] **Christopher:** So you're saying that actually some of the weight stigma that patient's experience may actually be doing the types of harms that we're trying to fix by traditionally thinking about talking about weight. Is that right?

[00:07:30] **Laura:** Correct. You also just have to think about when you're experiencing that form of discrimination and that form of stress the psychological impacts as well. So anxiety rates are higher. Depression rates are higher.

[00:07:41] Substance abuse rates are higher. Suicide rates are higher.

[00:07:44] **Christopher:** Now, in your talk, you said something about weight cycling. Can you describe how that relates to what we're talking about right now?

[00:07:50] **Laura:** Sure. So weight cycling, basically what we're talking about when we talk about weight cycling is yo- yo dieting.

[00:07:55] This is seen in people who are chronically trying to control their weight. And so it's people who are losing weight and repeatedly losing weight and gaining weight. The data on weight cycling is very mixed. I would love to be able to tell you that. We have really clear evidence that weight cycling causes harm.

[00:08:13] We have some evidence that weight cycling causes harm, but again, the problem with these studies is that they're very difficult to perform and they're very difficult to replicate. There's no uniform definition of what weight cycling is. And that makes the research a little bit flawed and conclusions difficult to draw out. But, It does appear to convey physiologic stress and a proinflammatory state. It's the body's attempt to maintain homeostasis, so every individual is going to have a homeostatic set point where their body is going to be happiest, a weight set point that's regulated by the hypothalamus.

[00:08:51] And this is why it's very difficult for people to lose weight and keep it off. What we know is that if you've been living at a higher body weight for a certain number of years, most likely a longer period of

years, your body adjusts to that higher set point and the thermostat can go up, but we don't know how to turn it back down again.

[00:09:12] And so when people try to calorically restrict or even if they're put on weight loss medications, even if they have weight loss surgery, when they go off those weight loss medications and after they adjust after their weight loss surgery, they're going to gain weight again. And so in people who have this pattern of weight loss and weight regain, we see markers of higher cardiometabolic risk. So fasting lipids look worse, higher rates of insulin sensitivity, higher rates of diabetes type two. And again, because of methodologic differences, it's hard to draw exact conclusions, but weight stigma contributes to the pressure that people feel that they should be living at a smaller body size.

[00:09:55] So they're going to these extreme measures to lose weight repeatedly over and over again, every time you do this, it makes it a little bit harder for you to do it the next time. Again, just causing more harm in the long run.

[00:10:07] **Christopher:** So that sort of brings into the next part of my question is... this is in the area that you have great interest in. How does weight stigma play a role in disordered eating?

[00:10:16] **Laura:** So we talk about disordered eating and eating disorders, they exist on a spectrum. Disordered eating is what we call a maladaptive or non normative pattern of eating could be restrictive, emotional eating, and every human being is going to eat out of emotion at some point. So emotional eating in and of itself is not necessarily disordered, but it becomes disordered when it's used as a maladaptive coping strategy for something else.

[00:10:44] The pressure that individuals who may be living in a larger body or perceive themselves to be living in a larger body because they're experiencing that weight stigma feel and internalize pushes them towards these maladaptive eating patterns. It could be an extreme restriction. We include behaviors such as binging, purging, over exercise, laxative abuse, diuretic use. We include all of that in the disordered eating, eating disorder behavior sort of bucket. So any of these behaviors are going to be more common in people who experience weight stigma. And people who are predisposed to developing an eating disorder can push them toward the development of an eating disorder.

[00:11:36] **Christopher:** And so it may be inadvertent from our standpoint as healthcare providers as we start talking about ways in which someone who might be at higher risk for eating disorders to start talking about weight and types of strategies that we've traditionally been taught. So can you talk a little bit about that as our role as healthcare providers and unfortunately perpetuating or maybe how we can maybe mitigate some of these issues.

[00:11:59] **Laura:** So, I like to try to help people identify what's within their realm of control and help them to own their agency and own their power. And so there's only so much that each of us as an individual can do over what the number on the scale is going to show so for some of my patients for a lot of my patients I won't even weigh them. For my patients who have anorexia who I'm trying to weight restore I mean getting a weight is not an option.

[00:12:29] They don't know their weight. I know their weight. No, so I'm not telling them what their weight is. But for my patients who I'm not concerned about weight restoration, I'm not necessarily weighing them and my patients know that they have the option to decline their weight. So that's one thing that I'm doing.

[00:12:46] I keep the focus off of their weight and their size. For a lot of patients who come in with decades of actual trauma from having gone to medical providers who made this such an emphasis. It can be very difficult. I keep a box of tissues in the room at all times. My medical assistants have extra boxes

of tissues that they can run in with when we run out, because it can be a very emotional conversation when you're first getting started.

[00:13:15] You need to make sure that they know that you're not giving up on them. You need to make sure that they know that you don't think that they're a hopeless case. And I've had patients express, "You're saying this because you just don't think that I can lose the weight."

[00:13:28] And that's not it. I don't think that they're hopeless. I don't think that they just lack the willpower. It's not about willpower. And I like to point out all of the things that demonstrate that they are very effective, functional, successful people. Most of them have good families, good jobs.

[00:13:47] They've been effective and successful at something, right? So emphasizing their strengths and helping them to identify how they can be agents of change. But then also identifying the things that are not within their control and the shape that their bodies take and the weight at which their bodies are going to stabilize outside of something like putting them on medication or undergoing bariatric surgery is not within their control.

[00:14:16] That's mainly going to be genetic and environmental factors, so they could restrict themselves all day and eat nothing, and their metabolism is just going to adjust for that, and they may not necessarily lose weight. Which is part of the definition of atypical anorexia. So patients with atypical anorexia may not be eating.

[00:14:35] But they don't lose weight and they have all the symptoms and medical complications of somebody who's starving. So with a lot of education, we go very slowly. And I try to emphasize the difference between weight and health. Everybody wants to be healthy. So we try to redefine what health is. I try to ask a lot of questions.

[00:15:02] What is most important to them? What are their goals? Do they want to be able to play with their grandkids? Do they want to be able to walk on their vacation without pain? Do they want to be able to come off some of their blood pressure medications? And then working towards those goals and trying to keep the conversation off of what the number on the scale is doing. So we talk about health behaviors. Are they getting enough sleep? How often are they eating? Are they eating regularly? What's the quality of the food that they're eating? I get them connected with a weight neutral dietitian trying to mitigate alcohol use if they're overusing alcohol. Stop smoking. All of those health behaviors that we talk about with all of our patients. We make that the emphasis.

[00:15:52] **Christopher:** This is something that I've changed over the years after listening to many of these types of talks from you and some of my other colleagues who are very focused on weight stigma. I think with my own personal practice, one thing I've changed is, I almost never bring up weight as a thing especially in my general preventative appointments. I talk about healthy lifestyles and making wise choices and things like that. And then if I feel like there's a reason I have to bring up a weight for any reason, I ask the patient's permission first. If they're okay talking about it, then that's in my personal practice.

[00:16:21] I think some of the things you're talking about brings back another patient, one of whom had a known eating disorder that was well controlled, when she would come in, at the time they're like, oh no, you always have to check your weight. But so we'd weigh her backwards so she would never look at the scale. And then when we print the after visit summary, I used to print it, run up to the front, cut out her weight from the after visit summary before giving it to her. I think actually here at OSU Epic, just. An update where you can actually hide the weight from the after visit summary.

[00:16:46] I definitely understand and hear everything that you're telling me right now. One of the things that I've heard over the years more recently as I've heard about weight stigma, is this healthy at every size movement. Do you know anything about that? And can you talk a little bit about that because I think providers may hear about this in different situations.

[00:17:03] **Laura:** Sure. So the health at every size is like a trademarked proprietary thing. There's a website, the association for size, diversity and health. The website is http://asdah.org/ and so healthy at every size or HAES. The HAES phrase is a trademarked phrase. So we talk about the non trademarked equivalent of that is weight inclusive medical care.

[00:17:26] And so what that is, is basically everything that we've been talking about up until this point is focusing on health rather than focusing on weight taking up an individual from the standpoint of their health and part of the HAES approach is identifying that health is going to mean something different to each individual and so it's very much patient centric and shared decision making centric.

[00:17:58] So having conversations with individuals about what health means to you and working with the individual patient to meet their goals. And so for some patients, they may not want to focus on certain things that you might think of as being healthy. And so accepting where they're coming from is one of the principles of the HAES approach.

[00:18:19] But there's several principles of HAES that are all outlined on their website, which is the Association for Size, Diversity and Health. And you can find that at ASDAH. org. Excellent.

[00:18:29] **Christopher:** Is there anything else that you want to let our audience know before we wrap up?

[00:18:33] **Laura:** No, it's just been a delight to be able to talk about this with you. Thank you so much for having me.

[00:18:38] **Christopher:** No I'm really happy to have you on. I think it gives us a balanced approach as well to think about, especially as so many patients come to us wanting weight loss medications. And then also now we should be really cognizant of making sure we're reviewing and talking about weight in a better, less stigmatizing way.

[00:18:55] I would love to have you come back to talk a little more about eating disorders specifically, which was outside the scope of our discussion today. And then also maybe even bring you and maybe our obesity medicine folks together at the same time and how we can address some of these issues as our patients that probably come with both, both at the same time.

[00:19:12] **Laura:** Absolutely. I think it does get complicated. I find one of the most difficult comorbidities to treat being non alcoholic fatty liver disease. So there are some medical conditions that the only treatment really is weight loss and so it can be very hard sometimes. It gets really muddy

[00:19:32] **Christopher:** Yeah, everyone's a little different and it all really comes to you as a physician doing very customized care with the patient, talking to them, doing shared decision making, and really trying to make the best choices with the patient together. Any points you'd like to summarize before we go?

[00:19:46] **Laura:** I think, my plea for all health care providers is to just be aware of your biases. There's data showing that health care providers spend less time with patients who are in larger body sizes, offer

less medication options and surgical options to patients with who are in larger bodies and just are offering lifestyle measures. And so there's data showing that people in larger bodies are following up less frequently, presenting less often for preventative health visits, including cancer screening, more likely to change physicians frequently. And so the thing that we can all do, I think, is to just approach each encounter with empathy and be aware of the language that we're using and ask ourselves, is this what I would offer any other patient? Is this how I would approach any other patient? And the same thing for office staff right down to the person at the front desk. So that would be my take home point.

[00:20:52] **Christopher:** That's great, thank you so much. And hopefully we'll have you back again to talk about some of the other great things that you can teach us.

[00:20:58] **Laura:** Thank you so much. This was really wonderful.

[00:21:01] **Christopher:** Awesome. Have a good day.

[00:21:02] **Laura:** Thanks. You too.

[00:21:03] **Christopher:** And for the rest of your listeners, Thank you again for listening to another episode of Everyday Medicine, a podcast from OSU's Division of General Internal Medicine. Please consider subscribing to our feed on your favorite podcasting platform so you don't miss out.

[00:21:20] You can also get our show notes and transcripts soon from our Division web page at http://medicine.osu.edu/GIM. Have a good day. Bye.