

Weight Bias in Healthcare: We Can Do Better

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Objectives

- Define and describe weight bias and its effects on health
- Identify the harms of a weight-loss centric approach
- Describe the principles of the “Health at Every Size” approach
- Promote health-enhancing strategies through a weight-neutral and health equity lens

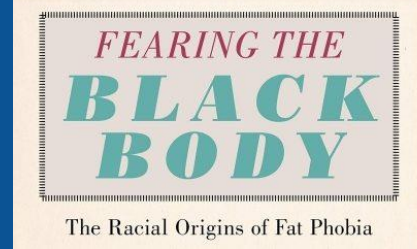
Acknowledgements

We are guests in this work

The origins of weight bias are rooted in racism

Body acceptance movement started by Black women and subsequently co-opted and whitewashed

Content may be triggering



Shifting the Language

Move Away From:

Underweight/Normal/Healthy
Weight

Overweight, obese

Obesity

Dieting

“Good” “Healthy” or “Clean” food

Consider Using:

Smaller body/ Person in a smaller body

Higher body weight/lives in a larger body

(Avoid)

(Avoid)

***whatever the patient uses

“Food” (does not have a moral value)

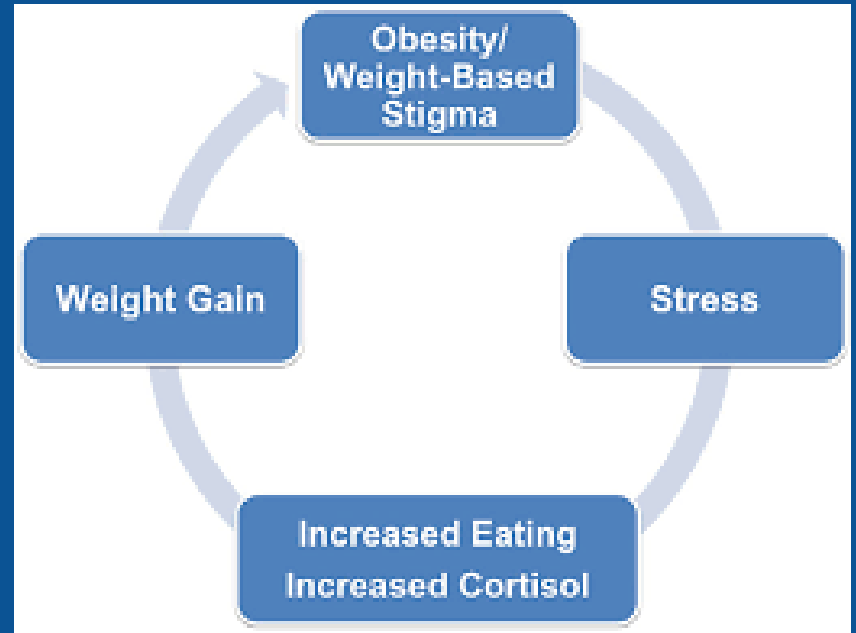
*More/less nutritionally dense food

Weight Bias...the last “socially acceptable” form of discrimination

- Weight bias (aka weight stigma): The social devaluation of people because of their body weight
 - Implicit or explicit
- Fatphobia: Dislike of people with larger bodies

Health Outcomes from Experiencing Weight Bias

- Depression
- Anxiety
- Low self-esteem
- Social isolation
- Weight gain
- Increased biological stress
- Increased mortality risk (60%)
- Increased suicidality
- Substance use



Body Mass Index

History of Use

Today's Use

Limitations of Use

Public Health Effects



Making Progress...

US Doctors' Group Adopts New Policy on Healthy Weight Assessment

By Nancy Lapid
June 15, 2023

+ Add to Email Alerts



1048



(Reuters) - The American Medical Association (AMA) on Wednesday said it will advise doctors to pay less attention to body mass index (BMI) in determining if a patient is at a healthy weight, saying the measure does not predict disease risk equally well across racial and ethnic groups.

BMI, a ratio of weight to height, has long been used to define underweight, "normal" weight, overweight, obesity and morbid obesity, despite mounting evidence that it is an inaccurate predictor of health risks on an individual level.

At the influential physician group's annual meeting in Chicago, members voted adopt a new policy that says BMI should be just one factor in determining whether a patient is at a healthy weight. Other measures such as body composition, belly fat, waist circumference, and genetic factors are also important, the AMA said.

There have been "issues with using BMI as a measurement due to its historical harm (and) its use for racist exclusion," the AMA said.

In its announcement on Wednesday, the AMA acknowledged that the BMI scale is based primarily on data from white people, while body shape and composition vary among racial and ethnic groups, genders, and age groups.

Socioeconomic Disparities as Root Causes of a Larger Body Size

- Stress in pregnancy
- Malnutrition
- Racism
- Grandmother and mother with larger bodies during gestation
- Formula fed
- High glycemic index, calorie dense, highly processed foods, exposure to endocrine disrupting chemicals
 - Public food programs, food pantry use
- Neighborhood unsafe for physical activity
- Body starvation (IUGR, poverty, long term weight cycling)
- Night shift work, inadequate sleep

Weight Bias is Pervasive...

- Childhood bullying
- Interpersonal relationships (family members, peers, teachers, coaches)
- Employment/hiring/job termination
- Education institution
- Media
- Health care

Not unique to U.S.

Occurs among all socioeconomic groups

Occurs along a spectrum of body sizes

Prevalence and Implications of Weight Bias in Healthcare

- Explicit and implicit bias documented among midwives, physicians, nurses, dietitians, mental health professionals
- Spend less time with people of larger bodies, develop less rapport
- Impact on clinical decision-making
- 70% of pregnant and postpartum persons with higher body weights experience weight bias from their providers

>>> *Leads to avoidance of health care and adverse health outcomes*






2023 PhD Study: Weight Bias Among Midwives

Journal of Midwifery & Women's Health

www.jm

Research Article

Weight Bias Among Certified Nurse-Midwives and Certified Midwives: Findings From a National Sample

Heather M. Bradford^{1,2}, CNM, PhD , Rebecca M. Puhl³, PhD , Julia C. Phillippi², CNM, PhD ,
Mary S. Dietrich^{2,4}, PhD, MS , Jeremy L. Neal², CNM, PhD 

Introduction: Weight bias toward individuals with higher body weights permeates health care settings in the United States and has been associated with poor weight-related communication and quality of care as well as adverse health outcomes. However, there has been limited quantitative investigation into weight bias among perinatal care providers. Certified nurse-midwives (CNMs)/certified midwives (CMs) attend approximately 11% of all births in the United States. The aims of this study were to measure the direction and extent of weight bias among CNMs/CMs and compare their levels of weight bias to the US public and other health professionals.

Methods: Through direct postcard distribution, social media accounts, professional networks, and email listservs, American Midwifery Certification Board (AMCB)-certified midwives were solicited to complete an online survey of their implicit weight bias using the Implicit Association Test and their explicit weight bias using the Antifat Attitudes Questionnaire, Fat Phobia Scale, and Preference for Thin People measure.

Results: A total of 2257 midwives participated in the survey, yielding a completion rate of 17.7%. Participants were mostly White and female, with a median age of 46 years and 11 years since AMCB certification. More than 70% of midwives have some level of implicit weight bias, although to a lesser extent compared with previously published findings among the US public ($P < .01$) and other health professionals ($P < .01$). In a subsample comparison of female midwives to female physicians, implicit weight bias levels were similar ($P > .05$). Midwives also express explicit weight bias, but at lower levels than the US public and other health professionals ($P < .05$).






Discussion: This study provides the first quantitative research documenting weight bias among a national US sample of perinatal care providers. Findings can inform educational efforts to mitigate weight bias in the perinatal care setting and decrease harm.
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Journal of Midwifery & Women's Health

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Research Article

Implicit and Explicit Weight Bias among Midwives: Variations Across Demographic Characteristics

Heather M. Bradford^{1,2}, CNM, PhD , Rebecca M. Puhl³, PhD , Julia C. Phillippi², CNM, PhD ,
Mary S. Dietrich^{2,4}, PhD, MS , Jeremy L. Neal², CNM, PhD 

Introduction: Weight bias toward individuals with higher body weights is present in health care settings. However, there has been limited quantitative exploration into weight bias among perinatal care providers and its potential variations based on demographic characteristics. The aim of this study was to examine if the direction and extent of weight bias among midwives certified by the American Midwifery Certification Board (AMCB) varied across age, years since certification, body mass index (BMI), race, ethnicity, and US geographic region.

Methods: Through direct email listservs, postcard distribution, social media accounts, and professional networks, midwives were invited to complete an online survey of their implicit weight bias (using the Implicit Association Test) and their explicit weight bias using the Anti-Fat Attitudes Questionnaire (AFA), Fat Phobia Scale (FPS), and Preference for Thin People (PTP) measure.

Results: A total of 2106 midwives who identified as Black or White and resided in one of 4 US geographic regions participated in the survey. Midwives with a lower BMI expressed higher levels of implicit ($P < .01$) and explicit ($P \leq .01$) weight bias across all 4 measures except for the AFA Fear of Fat Subscale. Implicit weight bias levels also varied by age ($P < .001$) and years since certification ($P < .001$), with lower levels among younger midwives (vs older) and those with fewer years (vs more) since certification. Only age and BMI remained significant ($P < .001$) after adjusting for other demographic characteristics. Lower explicit weight bias levels were found among midwives who identified as Black (vs White) on 2 measures (FPS: adjusted $\beta = -0.07$, $P = .004$; PTP: $P = .01$).

Discussion: This was the first quantitative study of how weight bias varies across demographic characteristics among a national sample of midwives. Further exploration is needed in more diverse samples. In addition, research to determine whether weight bias influences clinical decision-making and quality of care is warranted.

2023 PhD Study: Weight Bias Among Midwives

Aim 1: To describe implicit and explicit weight bias among AMCB-certified midwives and determine if it varies from the U.S. public and other health professionals.

Aim 2: To examine if the extent and direction of weight bias among AMCB-certified midwives varies by age, years since AMCB certification, BMI, race, ethnicity, and geographic region.

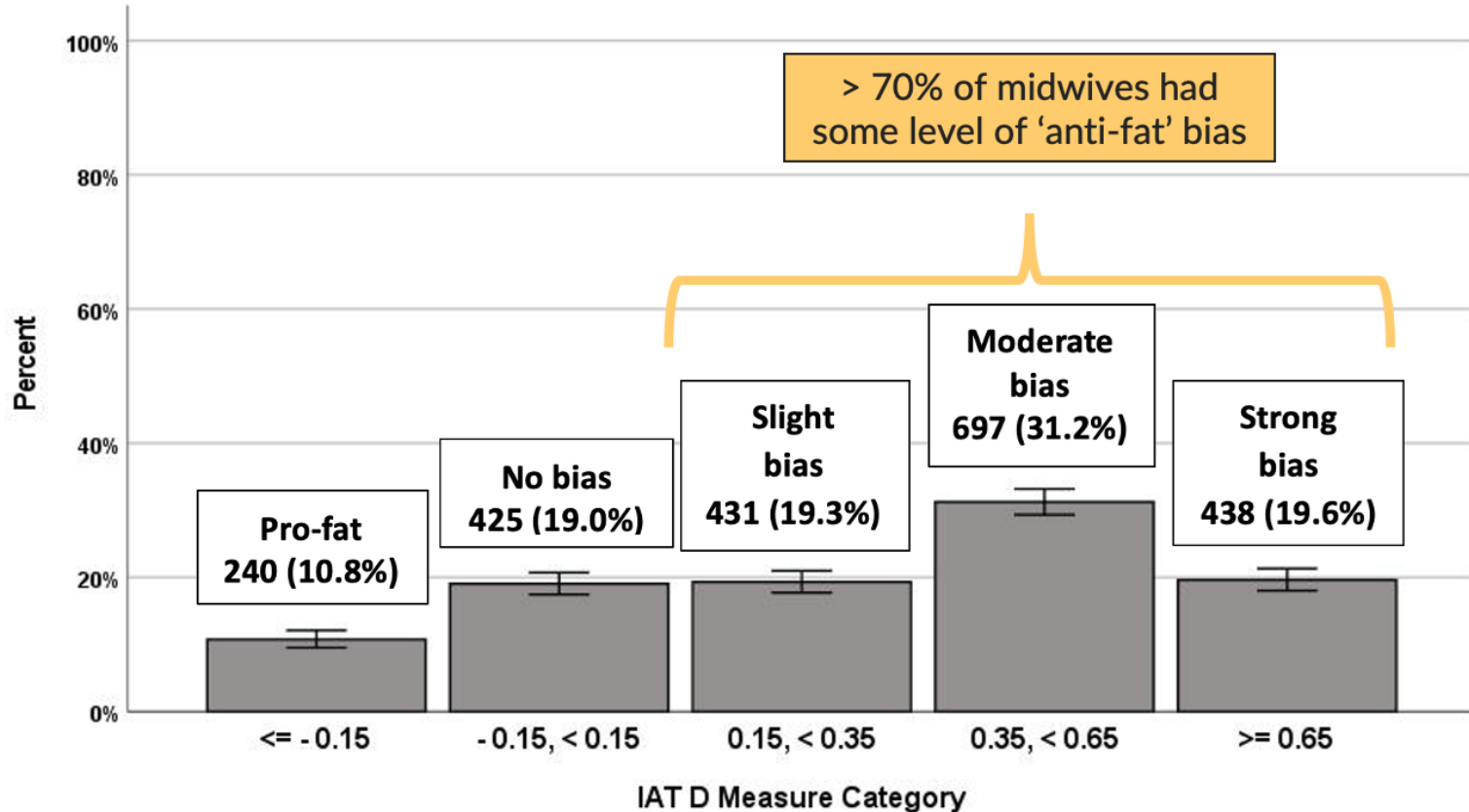
Characteristics of the Sample (N = 2,257)

Response rate 17.7%

Age (y), median (IQR)	46.0 (37.0, 58.0)
Body mass index (kg/m ²), median (IQR)	26.6 (23.2, 31.0)
Gender Identity	
Female	97.6%
Male	0.7%
Genderqueer or trans male	1.7%
Race	
Asian	1.4%
Black/African American	5.6%
White	88.4%
2 or more	3.5%
Other	1.1%
Hispanic or Latino Ethnicity	
No	94.8%
Yes	5.2%
Midwife Type	
Certified nurse-midwife	98.4%
Certified midwife	1.6%
Years since AMCB certification, median (IQR)	11.0 (5.0, 23.0)
CDC region	
Northeast	21.2%
South	30.1%
Midwest	21.0%
West	27.6%

Implicit Weight Bias (IAT)

D Score Scale: -2 to +2



Explicit Weight Bias Findings

Midwives have moderate levels of explicit weight bias but at lower levels than other health professionals and the US public

Things We May Say or Do as Clinicians

1. Encourage patients to pursue thinness/dieting
2. Congratulate weight loss
3. Make negative comments about your own or somebody else's size
4. Say or assume someone is doing well/unwell based on weight
5. Say something that assumes that a person in a larger body wants to lose weight
6. Say something that assumes people in larger bodies eat too much
7. Admire excessive exercise
8. Glorify chronic dieting
9. **Make weight a visit focus without consent/without it being relevant**

What if We Viewed Weight as Non-modifiable?

- Weight CAN be associated with certain conditions.
- Think of weight in same context as other non-modifiable conditions: “You are a carrier for a genetic condition....”

What Does the Science Say?

Intentional weight loss =
weight regain

Majority of “Weight
loss” studies do not have
long-term follow up

Weight cycling causes
harm to health

Size diversity is
biologically normal and
expected within a
species

There are better
predictors of health than
body size

Things that are Not Good for Health

Guilt

Shame

Forced Exercise

Restriction

Microaggressions

Judgement

Diagnoses Associated with Larger Bodies

- Dermatological concerns
- Post-op complications
- Mobility issues
 - Though not necessarily joint pain
- Weight cycling
- Eating disorders
 - Secondary to weight bias

Common (Ineffective) Weight Loss Recommendations

- Blanket recommendations for nearly all diagnoses
- “It’s just simple: diet and exercise”
- Caloric restriction
- Weight loss medications

Principles of Health At Every Size (HAES[®])

1. Weight Inclusivity
2. Health Enhancement
3. Respectful Care
4. Eating for Well-being
5. Life-Enhancing Movement

What HAES is not:

- NOT saying all people are healthy
- NOT saying that nutrition and exercise have no impact on health
- NOT anti-weight loss
- NOT saying that weight never has impact on health
- NOT a means to “have an excuse” and “give up”
- NOT just about intuitive eating
- NOT ONLY for those in larger sized bodies
- NOT anti-vegetable and anti-healthy habits



What Does Weight Inclusivity Look Like in Clinical Practice?

Journal of Midwifery & Women's Health

 Check for update
www.jmwh.org

Review

Mitigating Weight Bias in the Clinical Setting: A New Approach to Care

Signey M. Olson¹, CNM, WHNP-BC, DNP , Elizabeth G. Muñoz², CNM, DNP, Ellen C. Solis³, CNM, DNP, Heather M. Bradford¹, CNM, PhD 

Weight bias toward patients in larger bodies is pervasive among health care providers and can negatively influence provider-patient communication, as well as patients' behavior and health outcomes. Weight bias has historical roots that perpetuate thinness and Whiteness as the cultural norm. Although weight bias remains socially acceptable in US culture, contributing factors to an individual's body size are complex and multifactorial. Providers and health care systems also consistently use body mass index (BMI) as an indicator of health status, despite its limitations and harmful effects in the clinical setting. This state of the science review presents 8 evidence-based strategies that demonstrate how to mitigate harm from weight bias and improve quality of care and health outcomes for patients living in larger bodies. Person-centered approaches to care include (1) eliminating clinical recommendations to lose weight; (2) shifting from a focus on weight to health; (3) implementing a size and weight-inclusive approach; (4) engaging in weight bias self-evaluation; (5) creating a welcoming environment for patients of all sizes; (6) seeking permission and learning the patient's story; (7) using weight-inclusive language; and (8) re-evaluating clinical guidelines and policies based on BMI. Midwives and other health care providers may benefit from training that re-imagines the delivery of health care to patients in larger bodies.

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Olson S, Munoz E, Solis E, Bradford, HM. Mitigating weight bias in the clinical setting: A new approach to care. *J Midwifery Womens Health*. Published online Dec 2023 <https://doi.org/10.1111/jmwh.13578>

What Does Weight Inclusivity Look Like in Clinical Practice?

- Language
- Clinic policies
 - Weight check protocols, BMI cutoffs, pregnancy
- Size of chairs/examination tables/speculums/gowns
- Large enough bathrooms
- Body diversity on website/promotional material
- Waiting room reading materials that glorify dieting or thin bodies
- Consent to discuss nutrition/weight (patient-led; open questions)

Addressing Our Own Biases

- Recall health is not an indication of a person's value
- Consider how body size may intersect with their other identities

Most Important: Reframe thinking about bodies as to what they can do and how they feel, not how they appear or what they weigh

Clinical Care & Eating Disorders

- Best practice:
 - Screen all patients for eating disorders, regardless of size, prior to discussing nutrition or weight
 - *“Any history for you of eating disorders or chronic dieting?”*
 - If they screen positive for an eating disorder, **do not discuss nutrition or weight** and refer them to a HAES-informed registered dietitian
- When patients state they are going on a diet or desire weight loss:
 - Ask them what they hope to achieve
 - Help refocus their awareness toward other paths
 - If they’re open to it, talk about the science

When Might Taking a Weight be Required?

- Anesthesia/medication dosing
- Severely underweight patients
- Pediatric growth charts
- Post-op complication monitoring

What are Health-promoting Behaviors?

Challenge:

- Using appropriate weight-related language that is not shaming or stigmatizing to promote health-enhancing behaviors
- Develop a care plan for any diagnosis for someone in a larger body. Consider if this would be the same for someone in a smaller body.

Take-Home Points about Weight Bias

1. The majority of patients in higher body weights report stigmatizing experiences in health care settings
2. Weight bias can lead to avoidance of care and adverse health outcomes
3. We can do better:
 - a. Create a welcoming environment
 - b. Ask permission to discuss the topic
 - c. Use the patient's chosen language
 - d. Don't make assumptions about lifestyle

Closing Remarks

....we have the opportunity to heal the heart, mind, soul and body of our patients, their families and ourselves. They may forget your name, but they will never forget how you made them feel.

—Maya Angelou



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