



ASMBS Position Statement

ASMBS position statement on weight bias and stigma

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Preamble

The following position statement is issued by the American Society for Metabolic and Bariatric Surgery in response to numerous inquiries made to the Society by patients, physicians, Society members, hospitals, health insurance payors, the media, and others regarding weight bias, stigma, discrimination, and health disparities based on weight. In this statement, a summary of current, published, peer-reviewed scientific evidence and expert opinion is presented. The intent of issuing such a statement is to provide available objective information about these topics. The statement is not intended as, and should not be construed as, stating or establishing a local, regional, or national standard of care. The statement will be revised in the future as additional evidence becomes available.

Our understanding of the consequences of obesity on an individual's biology (e.g., diabetes and hypertension) and psychology (such as depression) continues to grow as the prevalence of obesity continues to increase. There is also a growing appreciation for social consequences of obesity and general bias based on an individual's weight. There is an early, but broadening, understanding of weight bias and its consequences on health outcomes. Indeed, there is reason

to suspect that the prevalence of weight bias has increased with the growing obesity epidemic. In fact, the perception of weight-based discrimination increases with body mass index (BMI) and has increased by 66% from 1995 to 2005, supporting the notion that it is the last socially acceptable form of discrimination [1,2]. Stress-induced pathophysiological effects of weight stigma (e.g., higher levels of cortisol, oxidative stress, and C-reactive protein) [3,4] and their influence on behaviors (e.g., the propensity of victims of bias to be more susceptible to unhealthy behaviors, such as overeating) [5] suggest a link between weight bias and health outcomes and may be essential in understanding "...the totality of effects of excess weight on health and well-being" [6].

Weight bias, generally defined as negative attitudes toward and beliefs about others because of their weight [1], can manifest as stereotypes (e.g., overweight people are lazy or weak-willed) [7] or frank prejudice (e.g., in employment/hiring decisions) against people with overweight or obesity [2,8,9]. Weight bias can lead to weight stigma, which involves actions against people with obesity that can cause their exclusion and marginalization, and can lead to inequities or discrimination in numerous settings, such as in the healthcare environment, and from a variety of sources, such as family and friends [10–12]. Individuals of all ages and sexes are susceptible to weight bias, although it may be perceived more frequently in younger patients compared with adults [13,14]. With >15% of children and

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adolescents affected by obesity, the effect of weight bias is a concern given the vulnerability of this population [15–18].

Weight bias can be explicit (i.e., consciously held negative attitudes, captured by self-report) or implicit (i.e., automatic, negative attitudes existing outside of conscious awareness) [19]. Although expressions of explicit bias, such as flagrant discrimination, may be decreasing in recent years, implicit bias helps to explain why weight-based prejudice continues to be pervasive.

Established theoretic frameworks are used to understand the social and psychological origins of weight bias in an attempt to explain its pervasiveness and social acceptability, and to help develop approaches to reduce such bias. Attribution theory, the most extensively tested framework in the area of weight stigma, suggests that “people attempt to search for information to determine the causes of uncertain outcomes,” and in turn formulate their reaction [6]. Therefore, stigma represents a society’s negative perception of a specific group. Along these lines, some authors suggest that weight bias could arise from positive values of self-determination and individualism, in which people’s own actions ultimately determine their fate and life situation [20–22]. Central to this theory is the perception that obesity is under the control of the individual and is consequently entirely reversible and that poor choices and behaviors leading to obesity can be changed at the discretion of the individual. The person with obesity, therefore, is to blame and is thus left defensive and isolated. Meanwhile, persons without obesity who hold these attributions feel morally superior and consider themselves safe from the threat of developing obesity.

Bias directed toward people with obesity has been documented in many spheres, including interpersonal relationships, employment and educational opportunities, the media, and healthcare [23]. Of note, Puhl and Brownell [14] demonstrated that healthcare providers were second only to family members as the most frequent source of weight stigma. Given that the success of any approach to mitigating the disease of obesity is predicated on the trust relationship of such patients and their healthcare providers, it is imperative that we understand and remedy weight bias within healthcare to effect sustainable change and alleviate the burden of this disease.

Weight bias within healthcare

Although healthcare in general, and obesity medicine specifically, are increasingly reliant on a multidisciplinary team of providers, the available data are not sufficiently comprehensive to detect weight bias and stigma in all disciplines. However, there is reason to suspect that this is a problem affecting many healthcare providers who care for patients with obesity.

Physicians

Primary care providers (PCPs) are often tasked with addressing the issue of obesity in their patients, and include

physicians, nurse practitioners, physician assistants, and clinical nurse specialists. However, most studies examining weight bias among PCPs involve physicians, although it is likely that all medical providers and different physician specialists are susceptible to weight bias. PCPs are required to manage all aspects of primary healthcare and in many systems are the gatekeepers to specialized care.

In this setting, it is presumed that the quality of care provided is not influenced by a patient’s weight given that all physicians aim to alleviate the morbidity and mortality associated with disease. However, multiple investigations have demonstrated that providers readily ascribe negative attributes to patients based on their weight. Specifically, interview studies of physicians demonstrate that a majority believe the etiology of obesity is related to behavior (e.g., lack of physical exercise, overeating, food addiction), with genetics and environment playing only a secondary role [24–27]. As such, there is a commonly held belief that management of obesity is the responsibility of the patient [25]. In addition, those providing counsel on weight loss and proper dietary habits themselves often still perceive the patients as lazy, lacking self-control, noncompliant and less likely to follow medical advice [28–30]. Finally, adjectives, such as “hostile” and “dishonest,” are also used to describe patients, suggesting negative attitudes of physicians are not only directed toward obesity as a disease, but also at patients who are affected by obesity [19,31]. As a result, physicians are less likely to spend time with such patients, perceiving the interactions to be a waste of time while simultaneously being more likely to order extra tests and recommend additional procedures [28]. Taken together, physicians express frustration in managing the disease of obesity; this is a frustration stemming from the perception that obesity is largely a behavioral problem, with treatments that are not only less effective than those for other chronic conditions, but that are also more time consuming to address [24]. These negative attitudes and bias are not exclusive to providers in the United States but are observed worldwide [25–27].

Beyond practicing physicians, evidence also suggests that weight bias is found in physician trainees. A study of >4000 medical students revealed that the majority of students demonstrated bias, with explicit bias toward people with obesity that was far greater than that toward several other often-stigmatized groups [32]. This finding accords well with a study of medical students by Wear et al. [33], which found that patients with obesity were the most common targets of derogatory humor by attending physicians, residents, and students. The common driver for these attitudes is the perception that the patient is to blame for their disease.

Nurses, dieticians, and exercise physiologists

Negative attitudes toward individuals with obesity and misconceptions about the causes of obesity are also

common among nurses. Patients with obesity are perceived by nurses to be noncompliant and thus, owing to poor personal choices, responsible for their own disease. This is the case despite their having a strong awareness of the presence of stigmatization of obesity [34,35]. In addition, Bagley et al. [36] suggested that nurses' dissatisfaction with their own weight negatively affected their attitude toward, or willingness to care for, patients with obesity. Furthermore, despite acknowledging the clinical impact of obesity on health and lifespan, many nurses may be reluctant to pursue the issue with their patients [36,37], perhaps out of concern for offending patients or straining relationships.

Other providers integral to the interdisciplinary management of obesity, such as dietitians and exercise physiologists, are also not immune to the pervasive bias toward patients with obesity. Describing patients as indulgent, slow, and insecure, or making assumptions that patients with weight issues have emotional or family problems, low self-esteem, or poor self-control, further demonstrates that weight bias can also present in providers who are specifically knowledgeable in obesity care. Studies have demonstrated that as with physicians and nurses, some dietitians and exercise physiologists believe patients are responsible for their disease because obesity is due to personal shortcomings, and resolution is therefore the responsibility of the patient [38–43].

Reasons for bias among healthcare professionals

The American Medical Association recognized obesity as a disease in 2013 [44]. Healthcare providers are aware of the clinical impact of obesity, its detrimental effects on overall health, and the complex nature of this disease, yet the care of patients with obesity is complicated by the stigmatizing belief on the part of providers that such patients should bear the responsibility for their own ailment and frustration in feeling unprepared to treat patients with obesity. Multiple studies investigating the perception of caregivers reveal consistent findings that although a majority of PCPs believe weight management is part of their role, they also feel inadequate and unprepared to address the problem [24,27,45–47]. Their perceived lack of preparation to address obesity is not surprising given that medical students in the United States receive an average of only 19.6 hours of nutrition education over the course of their training, representing <1% of their total curriculum hours [48]. Without sufficient education to understand obesity's complex etiology, the vast majority of internal medicine residents attribute obesity to behavioral factors, a belief that is associated with feeling unqualified to treat it [47]. Indeed, a third of internal medicine residents believe that treating obesity is "futile," an assumption that is likely sensed by patients [47]. Patients are often given weight loss objectives that are far more demanding than accepted guidelines, in addition to only

sporadic nutritional education and inconsistent instruction on the use of food diaries. Vague advice to "eat less and exercise more" is likely perceived by patients as unhelpful and stigmatizing, perhaps leading to avoidance of future medical appointments.

Other studies suggest that the weight of providers themselves affects their confidence in addressing obesity in their patients [49]. Conversely, Puhl et al. [50] demonstrated that when providers are perceived to have obesity by their patients, they are in turn subject to weight bias, in which such patients not only question the provider's credibility but are also less inclined to follow their medical advice.

Ultimately, physicians are reluctant to address the issue of overweight, resulting in erosion of the physician–patient relationship and lack of professional gratification. However, there is an increased recognition that improving physician knowledge and competency in the management and treatment of patients with obesity is an important component of training PCPs [51]. Studies suggest that providers with specific obesity training are more likely to approach it as a chronic disease and are thus likely to perceive their patients differently, perhaps reducing weight bias. Filling knowledge gaps among providers may encourage those who care for patients with obesity to address the issue of weight more routinely and enhance communication between patient and provider, increase trust, and improve care.

Patient perception

The perception of patients toward their providers, and the healthcare system in general, adds further complexity to the provision of optimal care in the presence of weight bias. Approximately 70% of patients with obesity perceive weight-based bias from physicians, with >50% reporting multiple incidents [14]. These perceptions are also observed in healthcare environments specializing in obesity care [52,53], albeit to a lesser extent.

The perception of bias can be a function of a hurried or ambiguous interaction between a patient and a provider, and the experience of a clinical environment that is not physically conducive to treatment, ultimately leaving patients feeling like "second-class citizens" [14,52,54]. Providers' language when discussing obesity may also play a role in unintentionally perpetuating weight-based stigma. Whereas research suggests that patients prefer more neutral terms, such as "weight" or "BMI," providers still commonly use disease-first language, such as "obese person," and terms such as "morbid obesity" that are viewed as pejorative and stigmatizing [55]. Consequently, patients often feel dissatisfied with the care they receive, are concerned that their providers are not sufficiently knowledgeable in obesity medicine, and are reluctant to address concerns about their weight because of fear that they will be judged, will not be taken seriously, or will not be managed appropriately [56,57].

Pervasive weight bias can also have dire consequences for individuals' health and well-being. Even when mental and physical health factors are controlled for, perceived weight discrimination increases risk of mortality by 57% [58] and is associated with increases in weight and poor glycemic control among those with type 2 diabetes [59]. Given that weight stigma is a chronic stressor, biochemical changes, coupled with emotional responses, may in turn contribute to overeating [60]. In addition, Hunger et al. [61] proposed that merely the threat of weight stigma may result in increased stress, undermined self-regulation, compromised psychological health, increased avoidance of stigmatizing domains (such as the gym), and engagement in unhealthy weight loss behaviors as a way of escaping the stigma.

Pearl et al. [62] also point out that cognitive appraisals of weight bias may be more predictive of negative outcomes than the experiences themselves. Indeed, when weight bias becomes internalized, persons with obesity adopt weight-based biases held by the culture at large, and thus feel worthless, ineffective, incompetent, and self-hate. Internalized weight bias has been associated with greater psychopathology, reduced social functioning, and poorer physical health [63,64]. While some may justify weight-shaming comments as motivating persons with obesity to lose weight, research suggests that weight bias has the opposite effect: those who internalize weight bias are more likely to engage in binge eating and are less motivated to lose weight [12]. Interestingly, some evidence suggests that patients' perception of bias and social discrimination is reduced after significant weight loss after bariatric surgery [65].

Bias in health insurance coverage

Weight bias impacts the relationship between patients and their health insurers. The treatments of chronic diseases, such as diabetes or hypertension, are comprehensively covered by most health insurance carriers. However, despite the fact that obesity is formally regarded as a disease and a recognized risk for multiple co-morbidities, health insurance coverage for the treatment of obesity is inconsistent and often insufficient [66,67]. It is common for insurance companies to not provide coverage at all or to limit the length and scope of treatment for obesity, which should include dietician consultation, weight loss pharmacotherapy, and bariatric surgery. The bias against coverage for specific obesity treatment can manifest as seemingly arbitrary barriers imposed on patients seeking treatment.

Most insurance carriers offering coverage for bariatric and metabolic surgery have established patient requirements, despite limited or no clinical evidence to support such requirements, including mandated preoperative weight loss, a required specific number of visits with a dietician, documented prior weight loss attempts, no weight gain while in a bariatric program, presence of severe obesity for a predetermined duration, and uncontrolled co-morbid

conditions despite maximal medical treatment [68–75]. Moreover, requirements vary from carrier to carrier and are often contradictory; some require preapproval weight loss, others demand a documented failure to lose weight despite best efforts, and others will deny coverage for patients who successfully lose some amount of weight. Furthermore, insurance carriers can take a “one and done” approach and refuse to cover revisional weight loss surgery or refuse to cover operative complications if the index operation was paid for by the patient.

The obvious consequence of such restrictions is denial of insurance coverage and access to care for seemingly arbitrary reasons. In addition, the effect of these constraints can lead to patient discouragement and attrition, with resultant progression of disease [76–78]. Meanwhile, patients with other chronic diseases, such as coronary heart disease or diabetes, are not subject to similar restrictions. Indeed, it would be considered ethically unacceptable and socially intolerable for insurance carriers to impose demands that are not evidence-based before approving coverage of treatment for patients with such chronic conditions or to impose limitations or a punitive schema after treatment is initiated.

The benefits of obesity treatments, including U.S. Food and Drug Administration-approved pharmacotherapy for obesity and bariatric surgery, are far-reaching and include cost-effectiveness and savings in health-related expenditures [79–81]. Nonetheless, many health insurance carriers refuse to cover these evidence-based treatments of obesity because of what are perceived as high up-front costs. Meanwhile other chronic diseases, such as diabetes or hypertension, are not held to a similar “cost-effective” standard. The American Society for Metabolic and Bariatric Surgery has been alert to these discriminatory barriers, recognizing this as an issue of inadequate access to effective treatment, stating that “...people who suffer from the disease of obesity should be free from prejudice and discrimination in accessing care for obesity” [82].

The pervasive discriminatory sentiment and seemingly arbitrary practices are further exemplified by public health coverage plans. Bariatric surgery, as an example, is not covered for state employees in 7 states, nor is it covered in many states for enrollees of plans created as part of the Affordable Care Act, which was passed in 2010. There is no cogent clinical or policy rationale for this, other than weight bias.

Impact of weight bias on provision of care

The obvious concern stemming from weight bias is that providers may lower the quality of care for patients with obesity. Providers who find weight management unrewarding or frustrating are less likely to spend sufficient time in the care of patients affected by obesity. Moreover, with poor reimbursement for such care, there is an additional disincentive to invest in these patients. Indeed, most surveyed physicians would spend more time on weight

management if it were properly reimbursed [24]. Differences in perceptions of obesity between physicians and their patients necessarily cause a rift in the patient–physician relationship, and thus hinder constructive and trusting communication. It is possible that a better understanding of the disease of obesity and improved knowledge of bariatric medicine could result in an increased likelihood of using multimodal approaches, such as pharmacotherapy and bariatric surgery. This could lead to less physician frustration in managing obesity. In fact, a self-administered survey of family physicians suggests that more education of PCPs is needed and should include treatment options, examination techniques, and community resources to improve care and decrease negative attitudes [83].

The negative attitudes perceived by patients cause them to be reluctant to seek healthcare in general, be averse to clinical examinations, and cancel or delay appointments because of embarrassment about their weight or fear of having gained weight [65,84,85]. In fact, Drury et al. [86], in surveying a sample of 216 women recruited from a church site, found that as BMI increased so did avoidance of healthcare in general for reasons, including having gained weight since the last healthcare visit, not wanting to be weighed on the provider’s scale, and knowing they would be told to lose weight.

This overarching problem extends well beyond the treatment of obesity. Obesity adversely affects age-appropriate cancer screening, leading to delays in breast, gynecologic, and colorectal cancer detection, despite patients with obesity having more frequent physician contact and known increased cancer incidence [87–90]. Specifically, Amy et al. [91] surveyed a sample of 498 women regarding access to gynecologic cancer screening and potential barriers that could cause delay. They found that lower rates of screening were related to patients’ weight and not a result of healthcare coverage because >90% of the women had health insurance. The barriers described by the participants included disrespectful treatment, embarrassment at being weighed, negative attitudes of providers, unsolicited advice to lose weight, and medical equipment that was too small to be functional. Therefore, women who delayed screening were significantly less likely to have timely pelvic examinations, Papanicolou tests, and mammograms, even though they reported that they were “moderately” or “very” concerned about cancer symptoms [91]. Other studies showed similar results [92,93].

Summary and recommendations

Weight bias is highly prevalent and affects multiple facets of society, including healthcare. It affects the physical and psychological health of patients with obesity and influences their access to and quality of care. The Obesity Action Coalition, a national organization advocating for individuals affected by obesity, defines weight bias as “...negative attitudes, beliefs, judgments, stereotypes, and discriminatory

acts aimed at individuals simply because of their weight. It can be overt or subtle and occur in any setting, including employment, healthcare, education, mass media, and relationships with family and friends. It also takes many forms—verbal, written, media, online, and more. Weight bias is dehumanizing and damaging; it can cause adverse physical and psychological health outcomes and promotes a social norm that marginalizes people” [94].

It is imperative to recognize weight bias and mitigate its detrimental effects. A broad-based effort of education on the disease of obesity, its causes, impact, and treatment approaches is an important first step. This would include the following:

1. Education on obesity as a chronic disease; advances in research and management: individuals with obesity must be treated by providers and insurers as other patients with a chronic disease. Obesity medicine should be part of medical training and should focus on increasing knowledge, competency, sensitive communication, and confidence in treating patients with obesity. Providers need greater guidance on how to raise the topic of weight loss in a nonstigmatizing manner and provide recommendations that are relevant, evidence-based, individualized, and realistic;
2. Sensitivity training to increase awareness for and reduce the impact of weight bias: there is a broad need for recognition of weight bias, the challenge of living with obesity, and the difficulty of weight loss. In addition, the emotional and health consequences of being stigmatized must be recognized and appreciated. Providers bear the responsibility for ensuring their provision of care is not, to the best of their ability, affected by biases. Providers must ensure their office and hospital environments are conducive to caring for patients with obesity;
3. Improved knowledge of resources: patients and their providers should be familiar with multimodal management options for obesity and local, community, state, and national resources. Payor policies should be continuously monitored by patients, providers, and advocates to ensure evidence-based, bias-free coverage of the medical and surgical treatment of obesity;
4. Facility resources must be made available: specific accommodations are needed to appropriately treat people affected by obesity. These include, but are not limited to, furniture (e.g., chairs, exam tables, operating room tables, hospital beds, wheelchairs, etc.), equipment (e.g., blood pressure cuffs, scales, sequential compression devices, etc.), and facility changes (e.g., doorways, floor-mounted toilets, etc.); and
5. Educate the public: education of the public is essential for the meaningful implementation of the above recommendations. Effective use of media and other resources are needed to enhance the public understanding of the chronic disease of obesity and the risks of obesity stigma.

Weight bias and stigma position statement and standard of care

This Position Statement is not intended to provide inflexible rules or requirements of practice and is not intended, nor should it be used, to state or establish a local, regional, or national legal standard of care. Ultimately, there are various appropriate treatment modalities for each patient, and the surgeon must use his or her judgment in selecting from among the different feasible options. The American Society for Metabolic and Bariatric Surgery cautions against the use of this Statement in litigation in which the clinical decisions of a physician are called into question. The ultimate judgment regarding appropriateness of any specific procedure or course of action must be made by the physician in light of all the circumstances presented. Thus, an approach that differs from this statement, standing alone, does not necessarily imply that the approach was below the standard of care. To the contrary, a conscientious physician may responsibly adopt a course of action different from that set forth in the Statement when, in the reasonable judgment of the physician, such course of action is indicated by the condition of the patient, limitations on available resources, or advances in knowledge or technology. All that should be expected is that the physician will follow a reasonable course of action based on current knowledge, available resources, and the needs of the patient to deliver effective and safe medical care. The sole purpose of this Position Statement is to assist practitioners in achieving this objective.

Disclosures

The authors have no commercial associations that might be a conflict of interest in relation to this article.

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