Health at Every Size / Weight-Inclusive Care

Workshop #1

November 8 2023

Dr. Katarina Wind



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Some images have been removed for copyright purposes

Welcome!

- First of 4 workshops
- Some of you are aware of HAES principles, others are newer, both are great!
- This will **contradict** much of what you've learned in medicine and life
  - It will TAKE TIME to unpack this internalized structural systemic fatphobia.
  - Be gentle with yourself.
- It also might be triggering
  - At any time please feel free to turn off your camera, take a break, or leave
  - Need help?
    - Physician Health Program 24-Hour Help Line 1-800-663-6729
    - KW: katarina.e.wind@gmail.com

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It’s okay to learn and change!!



I am delivering this workshop from Vancouver, BC. This is the **traditional, unceded (stolen), and ancestral** territory of the xʷməθkʷəy̓əm (Musqueam), Sḵwx̱wú7mesh (Squamish), and Sel̓íl̓witulh (Tsleil-Waututh) Nations.

The medical community continues to stigmatize and harm these groups.

We have used the medicalization of body size and the judgement of foods belonging to various cultures, to continue to perpetuate racism in a more "socially acceptable" way.

As privileged medical providers, we must continuously re-evaluate our practices with humility.

Who are we?

Katarina Wind, MD
Family and Hospitalist Physician

Anne McGladdery, MD
Family Physician Resident

Confidentiality

- People may be sharing personal and vulnerable experiences and so anything said by fellow participants must not be shared outside of the group
  - NO expectation to share, only what feels comfortable
  - This is not being recorded
- What you CAN share:
  - Didactic content
  - Your own reflections
  - Stories shared by KW

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Outline for today:

- What is the “Weight-Centric” Model of care?
- Framework for analyzing weight-centric data – practice exercise
- The 5 myths of weight-centric medicine

Let’s get started!

- **Excerpt from "What we don't talk about when we talk about Fat" , by Aubrey Gordon**
- [Aubrey presented to urgent care for sudden hearing loss, she lives in a body medicine would classify as "obese"]

The nurse who greeted me was kind and warm. We talked freely as she took my vital signs, though our conversation was complicated by my failing hearing. She took my blood pressure, then looked at the cuff with a crooked frown. She took my blood pressure again, then made the same face. She excused herself to get another cuff – larger, this time.

I felt my heart beating in my throat. *What if something's wrong? What if my ears are just a symptom of something more sinister, more alarming? What if this is the death they've so long said was coming for me?*

"What's the matter?" I asked, trying to temper the frightened shake of my voice.

"I'm just not getting a good read", she said, adjusting the cuff once again.

"Is everything okay?" I asked, more afraid than before.

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“It’s coming back great,” she said, the good news belied by her befuddled tone. “But that can’t be right. Obese patients don’t have good blood pressure.”

She had learned that being fat meant being sick, and invariably, that sickness would lead to death. Just looking at me, she became certain that I must be in poor health. And her certainty was so great that it overrode the data in front of her. My sickness was inevitable, so good health was unfathomable.

I entrusted her with my health, and she couldn’t see it.

Excerpt from “What we don’t talk about when we talk about fat” by Aubrey Gordon, 2020

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What is the “Weight-Centric” Model of Care?

The weight-centric model of care

- “Fish don’t know they’re in water” – David Foster Wallace (adapted)
- This model assumes the following “a priori”
  - The BMI is a neutral and accurate measure of health
  - Any weight above the “normal BMI” is a risk factor for morbidity and mortality
  - People gain weight because they eat more and exercise less “Calories in, calories out”
  - Sustained, significant weight-loss is an achievable and beneficial goal
- ”Science is not value-free”
  - When we assume the above, we analyze our data differently than if we didn’t already think we knew what the data shows

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But, XYZ trial demonstrated that being “obese” was a risk factor for this disease, and that weight loss was helpful?

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Analyzing weight-centric data

- Correlation ≠ Causation (for studies that associate higher weights with poor health outcomes)
  - Weight stigma/bias
    - In health care
      - Health care avoidance, poorer health care (less investigations, less time with patients)
      - Patients in larger bodies excluded from research, certain medications (ex: Morning-after pill) less efficacious
    - Outside of health care
      - Bullying/harassment, workplace discrimination, lowered self-esteem
  - Weight cycling
  - Diet drug use / bariatric surgery
- Conflicts of interest
  - Funding from companies that sell weight loss medications and/or programs

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Analyzing weight-centric data

- Is the study appropriately controlled?
  - The “intervention” group may be in a weight-loss clinic that also rigorously manages co-morbidities and provides close follow up. If we didn’t assume weight-loss was beneficial a priori, we would have **both** groups at the clinic, but only one group prescribed the calorie restriction
- Is the intervention appropriate, and culturally safe?
  - (ex: some of the more “successful” interventions have participants consume only meal-replacement shakes)
- Does the study measure **risks** of weight loss interventions?
  - Ex: Pre-screen for eating disorders or monitor for eating disorder development? Assess for weight-cycling, mental health, osteoporosis?
- Does the study evaluate **long-term** (2-5+ years) outcomes?
  - Many interventions **do** result in short-term weight loss, however, the vast majority of longer term studies show most participants regain back to their baseline weight, or higher
- Does the study assume those lost to follow-up maintained the same weight?

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The 5 myths of weight-centric medicine:

1. BMI is a neutral and accurate health measure
2. People become “overweight” or “obese” because they make poor dietary choices and don’t exercise
3. Being “overweight” or “obese” increases morbidity and mortality , and intentional weight loss reverses this
4. Encouraging patients to lose weight, is helpful and harmless
5. Science is value-free

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Origins of the BMI

Adolphe Quetelet

Ancel Keys

* Not doctors

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The New York Times

A.M.A. Recognizes Obesity as a Disease

Medscape Internal Medicine

NEWS & PERSPECTIVE DRUGS & DISEASES CME & EDUCATION ACADEMY CONSULT

News > Medscape Medical News > Conference News > American Medical Association (AMA) 2013 Annual Meeting

AMA Declares Obesity a Disease

Marcia Frellick
June 19, 2013

CANADIAN MEDICAL ASSOCIATION RECOGNIZES OBESITY AS A CHRONIC DISEASE

Posted by Dr. Sue Pedersen | Oct 16, 2015 | Media

ASSOCIATION MÉDICALE CANADIENNE

CANADIAN MEDICAL ASSOCIATION

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Obesity is derived from the Latin *obesus*, meaning “having eaten oneself fat,” inherently blaming fat people for their bodies. Instead, the word *fat* is being reclaimed by the Fat Justice community as “an objective adjective to describe our bodies, like tall or short”.

– Aubrey Gordon

Other descriptors:

- Straight size / plus size
- Smaller fat / medium fat / large fat
- Larger body / smaller body
- Higher weight / lower weight
- No comment on size!

Original image was in this article:
https://highline.huffingtonpost.com/articles/en/everything-you-know-about-obesity-is-wrong/

Quote: What we don’t talk about when we talk about fat, Aubrey Gordon 2020

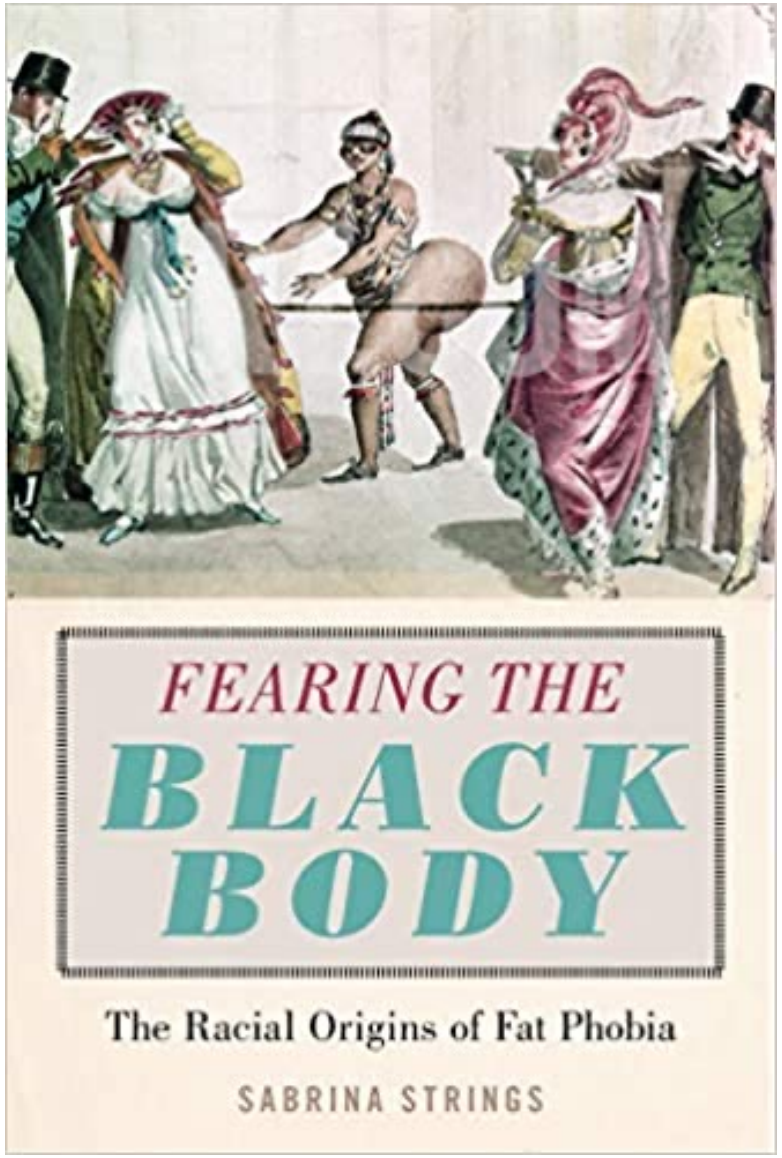
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“I see people – particularly those who aren’t fat – get startled or confused when they hear the word for the first time in a context that isn’t negative” – Chloe Papa

https://www.abc.net.au/everyday/unpacking-and-reclaiming-the-word-fat/11726100

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“The conflation of obesity with racialized and colonized communities is part of a long tradition of marking marginalized populations as diseased”.



Quote: McPhail D, Orsini M. Medicine and society: Fat acceptance as social justice. Cmaj. 2021;193(35):E1398–9.

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Remember homeostasis?

Image source: https://askabiologist.asu.edu/bird-hypothalamus

Remember homeostasis?

- Temperature
- Blood pressure / volume
- Blood glucose
- **Body weight**

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What is the “Set Weight”?

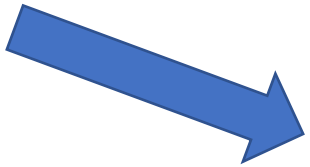
Set temperature: 36-38 Celsius

Set weight: Determined by genetics, hormones etc

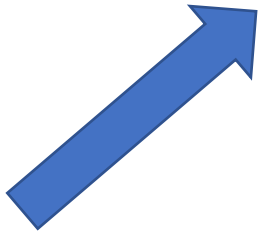
Image 1 source: https://askabiologist.asu.edu/bird-hypothalamus
Image 2 source: University of Arizona – Nutrition - Health at Every Size: Why It’s Not Anti-Health

The Set Weight

- Genetics
- Age, sex, race
- Illness (malignancy, hypo/hyperthyroid)
- Medications
- Pregnancy
- Food access (physical or mental – ex: dieting)



Complex neurohormonal control:
Ex: Insulin, cortisol, leptin, ghrelin, GLP-1/2, glucagon, estrogens etc.



- Hunger cues
- Taste
- Energy level
- Metabolism
- Gut absorption

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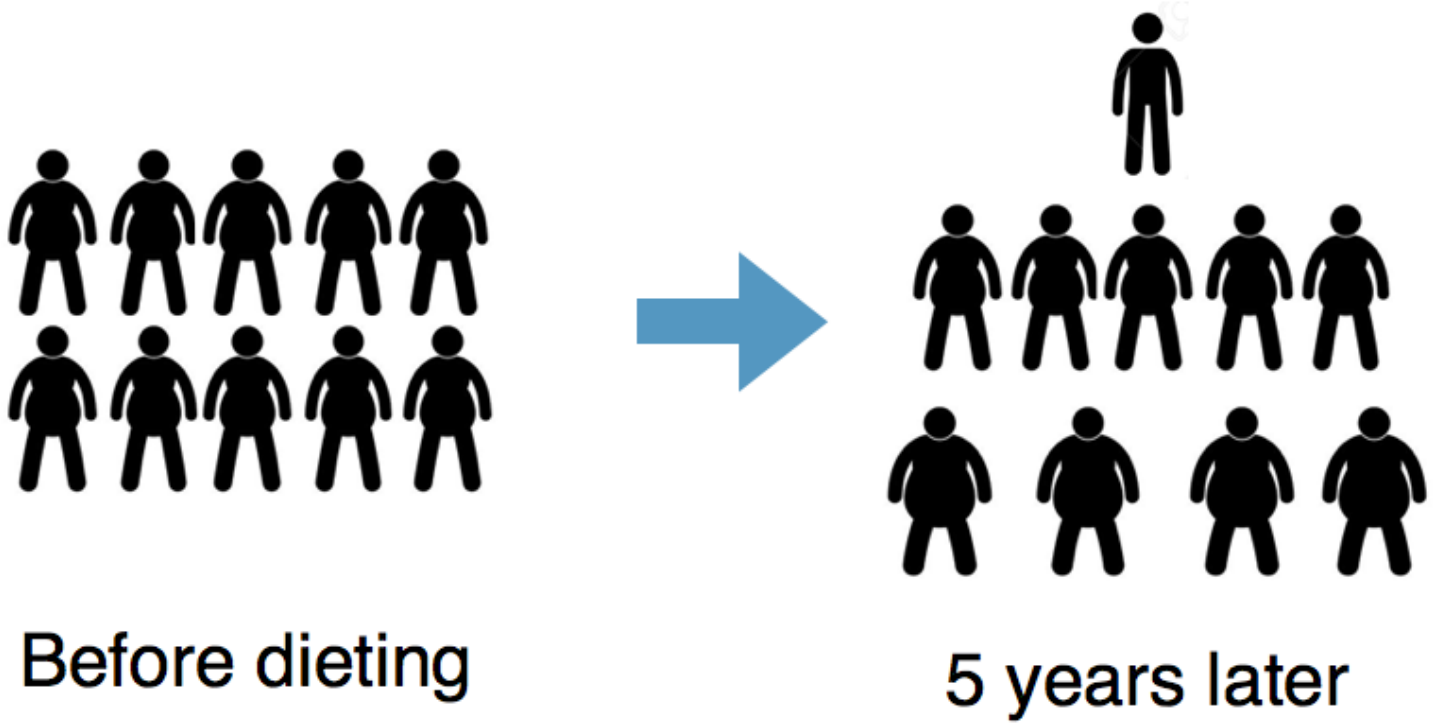
Image source: University of Arizona – Nutrition - Health at Every Size: Why It's Not Anti-Health

The Set Weight

- Instead of respecting set-point theory, we calculate a patient's "ideal weight" based on the "normal BMI"
- The body doesn't know about BMI cut-offs!

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Weight *gain* is a more likely outcome of dieting than weight *loss*



*** More on this in upcoming workshops

Mann, et al. 2007. *Am Psychol,* Fildes et al. 2015. *Am. J. Public Health*

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Reflections? Questions?

- Do you assume a pregnant woman gains weight because of lifestyle changes?

- Imagine the pregnant woman didn’t realize she was pregnant and tried to prevent the weight gain. How do you think she would feel, physically and emotionally?

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Image Source: Kate Pittman, This is not a diet – this is your Life

The 5 myths of weight-centric medicine:

#2: People become “overweight” or “obese” because they make poor dietary choices and don’t exercise

BUSTED:

- **Control of weight is highly complex and not under the control of “will-power” long term.**
- **A person’s Set Weight can be within the “overweight” or “obese” categories.**
- **Dieting often increases the set weight.**

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The Obesity “Paradox”

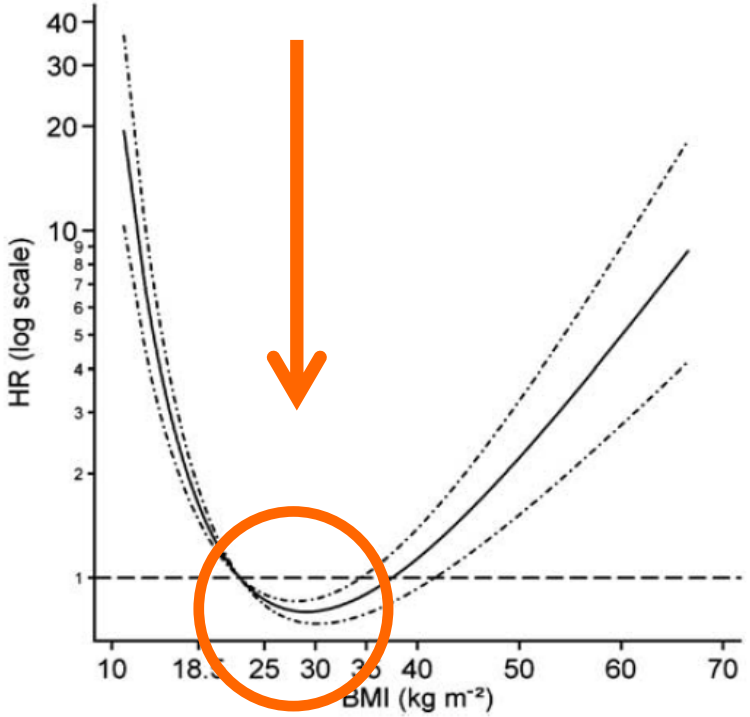


Figure 1 Functional form of the association of BMI with the relative hazard of death estimated in a Cox proportional hazards model adjusted for age, gender, smoking, alcohol consumption and survey year. The function was fitted using two-term fractional polynomial functions with powers (log, log). The function was standardized such that the HR was 1 at the mean of the desirable weight category for BMI (18.5–<25 kg m^{-2}) = 22.57 kg m^{-2}. Dot-dash lines indicate the 95% confidence interval.

BMI	HEALTH RISK
<18.5	~~"underweight"~~ *greatest health risk*
18.5 - 24.9	~~"normal weight"~~ *30% "unhealthy"*
25 - 29.9	~~"overweight"~~ *lowest death rate*
≥30	~~"obese"~~ *30% "healthy"*

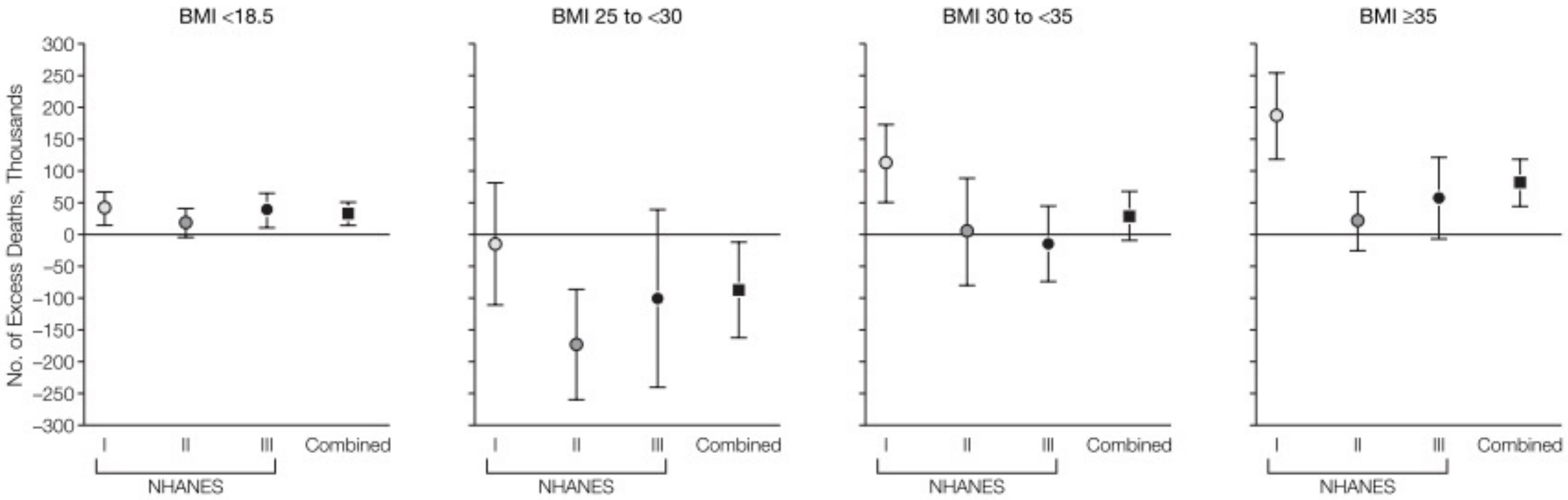
@alissarumseyRD as seen in *Unapologetic Eating*

Inter J of Obesity 35:838-851, 2011 (Scottish population)

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The Obesity “Paradox”

Figure 2. Estimated Numbers of Excess Deaths in 2000 in the United States Relative to the Healthy Reference BMI Category of 18.5 to <25, Shown by Survey and BMI Category



BMI indicates body mass index (measured as weight in kilograms divided by the square of height in meters). All estimates are based on the covariate distribution from NHANES 1999-2002, the number of deaths in 2000 from US vital statistics data, and the relative risks estimated from National Health and Nutrition Examination Surveys (NHANES) I, NHANES II, NHANES III, or the combined NHANES I, II, and III data set. Error bars indicate 95% confidence intervals.

K.M. Flegal, B.I. Graubard, D.F. Williamson, M.H. Gail**Excess deaths associated with underweight, overweight, and obesity**
JAMA., 293 (15) (2005), pp. 1861-1867, 10.1001/jama.293.15.1861

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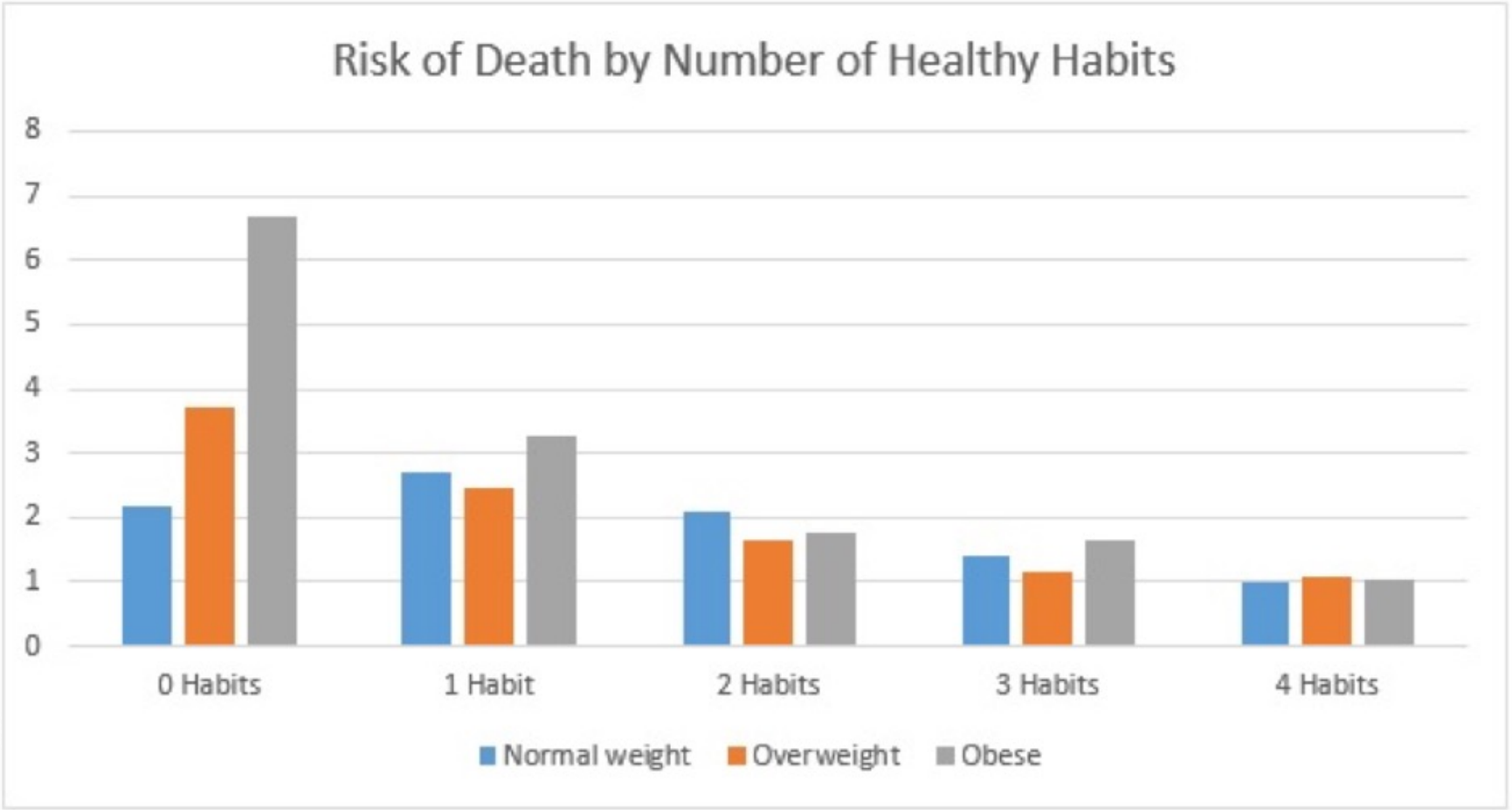
BMI, behaviours and mortality risk

When controlled for lifestyle behaviors, BMI-mortality relationship disappears

Used NHANES III data, weighted sample size of 133 million (18 mil deaths), av 170 month follow up

Habits

- ≥5 Fruit+/Veg
- >12 x month leisure time physical activities
- Not smoking
- > 0-1 alcoholic drink/day for women and 2 for men

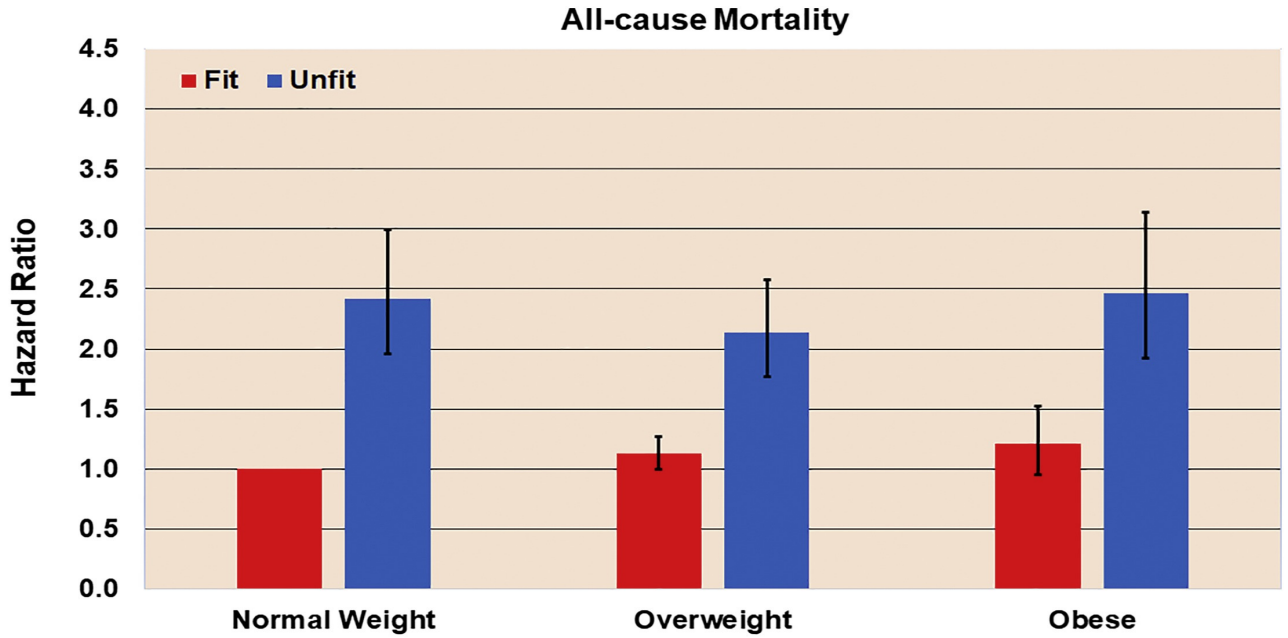


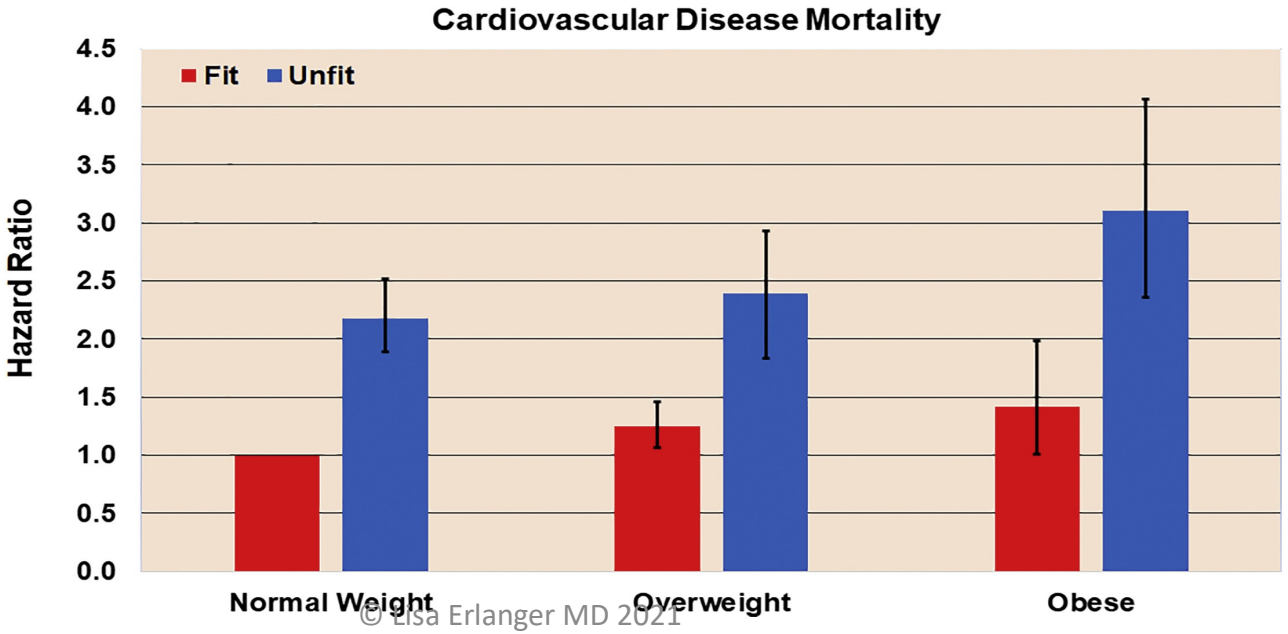
Matheson EM, King DE, Everett CJ. Healthy lifestyle habits and mortality in overweight and obese individuals. The Journal of the American Board of Family Medicine. 2012 Jan 1;25(1):9-15.

Slide from Fiona Willer

Weight Loss Vs. Fitness for Reducing Health Risks

Gaesser, Angadi, iScience, 2021





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Up to 75% of “obese” individuals are metabolically healthy

Model: Joy Cox
Photographer: **FINLAY MACKAY**

Original image was in this article:
https://highline.huffingtonpost.com/articles/en/everything-you-know-about-obesity-is-wrong/

“There is so much agency taken from marginalized groups to mute their voices and mask their existence. Being depicted as a female CEO—one who is also black and fat—means so much to me. It is a representation of the reclamation of power in the boardroom, classroom and living room of my body. I own all of this.”—JOY COX

Myth 3 ctd: …. intentional weight loss reverses morbidity and mortality associated with “obesity

- Weight *loss*, even when intentional, “*increases* the risk of premature death among ‘obese’ individuals”
  - Even when controlling for confounders including underlying disease and hazardous behavior

Bacon L, Aphramor L. Weight science: Evaluating the evidence for a paradigm shift (Health at every size). Clin Nutr Interface Between Metab Diet, Dis. 2013;335–66.

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92. Williamson DF, Pamuk E, Thun M, Flanders D, Byers T, Heath C: Prospective study of intentional weight loss and mortality in overweight white men aged 40-64 years. Am J Epidemiol 1999, 149:491-503.

93. Andres R, Muller DC, Sorkin JD: Long-term effects of change in body weight on all-cause mortality. A review. Ann Intern Med 1993, 119:737-743.

94. Yaari S, Goldbourt U: Voluntary and involuntary weight loss: associations with long term mortality in 9,228 middle-aged and elderly men. Am J Epidemiol 1998, 148:546-555.

95. Sørensen T, Rissanen A, Korkeila M, Kaprio J: Intention to lose weight, weight changes, and 18-y mortality in overweight individuals without co- morbidities. PLoS Med 2005, 2:E171.

96. Simonsen MK, Hundrup YA, Obel EB, Gronbaek M, Heitmann BL: Intentional weight loss and mortality among initially healthy men and women. Nutr Rev 2008, 66:375-386.

97. Ingram DD, Mussolino ME: Weight loss from maximum body weight and mortality: the Third National Health and Nutrition Examination Survey Linked Mortality File. Int J Obes 2010, 34:1044-1050

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Reflections? Questions?

The 5 myths of weight-centric medicine:

1. BMI is a neutral and accurate health measure
2. People become “overweight” or “obese” because they make poor dietary choices and don’t exercise
3. Being “overweight” or “obese” increases morbidity and mortality , and intentional weight loss reverses this
4. **Encouraging patients to lose weight is helpful and harmless**
5. Science is value-free

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Even if you think weight-loss is beneficial…

- Discussing weight loss paradoxically results in overall weight gain
- Regardless of current body size, “perceiving oneself as being ‘overweight’ is counter-intuitively associated with overeating in response to stress… [and] an increased risk of future weight gain
- The experience of weight stigma is also associated with future weight gain.

Sources:

Sutin, A and Terracciano, A. Percieved Weight Discrimination and Obesity, PLOS ONE, 2013.

Jackson, S. et al. Perceived weight discrimination and changes in weight, waist circumference, and weight status, Obesity (Silver Spring), 2014

Robinson, E. Et al. Perceived weight status and risk of weight gain across life in US and UK adults. Nature. 2015.

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Even if you think weight-loss is beneficial…

- We will discuss more about the harms in the next workshop, in particular, about weight-cycling

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HALF-WAY BREAK

The 5 myths of weight-centric medicine:

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5. **Science is value-free**

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Myth 5: Science is value-free

- Funding from a multi-billion dollar “wellness” industry – pharmaceuticals, “WW”, “Noom” etc.
- Many of us benefit from thin privilege – it can be hard on egos to realize that being thin is not a “virtue”
- We have been raised in a world infiltrated by diet culture – and many of us have internalized disordered eating behaviors – it can be scary to realize that these are not actually helpful
- *Both the science itself, and the interpretation of the science, are influenced by our culture*

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You’re wrong …. I took control of my health, started exercising more, lost weight, and I feel better!

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Myth 5: Science is value-free

- I want to acknowledge that we all come to this data with our own story of our relationship with weight and health.
- And **it is that VERY DIVERSITY of experiences that makes HAES valid.**
- We analyze data with a "Does it make sense?" lens, that is based on our personal experiences
- Personal experience of white, cis, straight, high SES men is **different** from personal experience of others. These are the people historically most involved in research, guidelines, and policy regarding weight
  - Men lose more weight: Effectiveness of weight loss interventions – is there a difference between men and women: a systematic review. Williams, 2014. Obesity reviews. https://onlinelibrary.wiley.com/doi/full/10.1111/obr.12241

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Summary so far:

- The origins of the BMI and “obesity” as a disease are racist, arbitrary, and biased by insurance/pharma companies
- Control of weight is powerful and complex, the body has many mechanisms to return to the “set weight” , and dieting is proven to increase this “set weight”
  - “Prolonged weight suppression is not possible for the majority of people” AND is often harmful (in some studies increases long-term mortality)
- Associations between higher weights and poor outcomes do **not** prove causation
  - Studies are usually biased
  - Confounding factors can be poor care and stigmatization, weight cycling

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Common argument: Sure that may be true… but obesity is still a DISEASE if it's associated with certain risks/problems

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I invite you to consider body size as part of **identity**, rather than as a disease:

- Some other things that are associated with certain health outcomes that we don't regard as a DISEASE:
  - Sex
  - Race
  - Sexual orientation
  - Pregnancy
  - Menopause
- Body size is also a visible part of a person's **identity** that follows them everywhere they go
- Body size is also an area where certain groups (ex: race, sex, age) are more discriminated against than others
- Body size is **not** modifiable long-term, for the majority of people, without interventions that involve substantial risk

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Would you accept an intervention that extended your lifespan by 5 good-quality years, but also made you gain 25 pounds?

If the answer is not an immediate yes, then this highlights that the desire to be thin in our society is not largely about health.

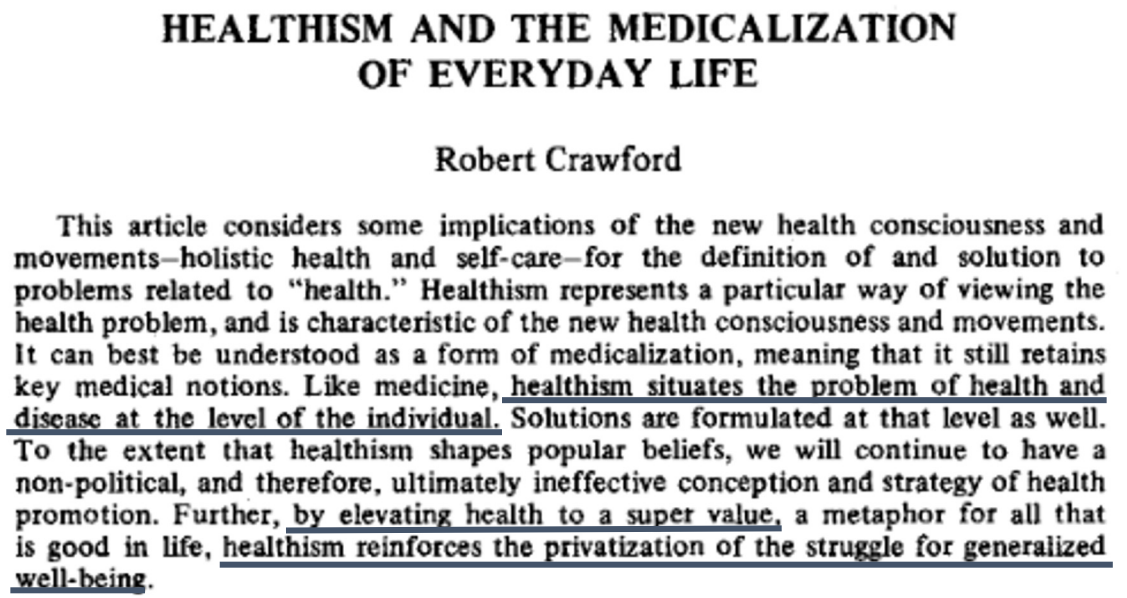
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A note on “Healthism”

What is “Healthism”?

- Defined as: “the preoccupation with personal health as a primary–often *the* primary–focus for the definition and achievement of well-being” and the idea that “health problems are behavioural, solutions are seen to lie within the realm of individual choice.”

- Overlying assumption that health comes from “the individual’s determination to resist culture, advertising, institutional and environmental constraints, disease agents, or, simply, lazy or poor personal habits”



HEALTHISM AND THE MEDICALIZATION OF EVERYDAY LIFE

Robert Crawford

This article considers some implications of the new health consciousness and movements–holistic health and self-care–for the definition of and solution to problems related to “health.” Healthism represents a particular way of viewing the health problem, and is characteristic of the new health consciousness and movements. It can best be understood as a form of medicalization, meaning that it still retains key medical notions. Like medicine, healthism situates the problem of health and disease at the level of the individual. Solutions are formulated at that level as well. To the extent that healthism shapes popular beliefs, we will continue to have a non-political, and therefore, ultimately ineffective conception and strategy of health promotion. Further, by elevating health to a super value, a metaphor for all that is good in life, healthism reinforces the privatization of the struggle for generalized well-being.

Crawford, R.E. (1980). Healthism and the Medicalization of Everyday Life. *International Journal of Health Services, 10*, 365 - 388.

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Healthist Assumptions

- It is virtuous to be healthy; health is a moral obligation
- Healthy people have more inherent value than unhealthy people
- Relies on a just world philosophy: “people get what is coming to them”
- Illness or disease is shameful, as it is a result of a lack of personal responsibility

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Critiques of Healthism

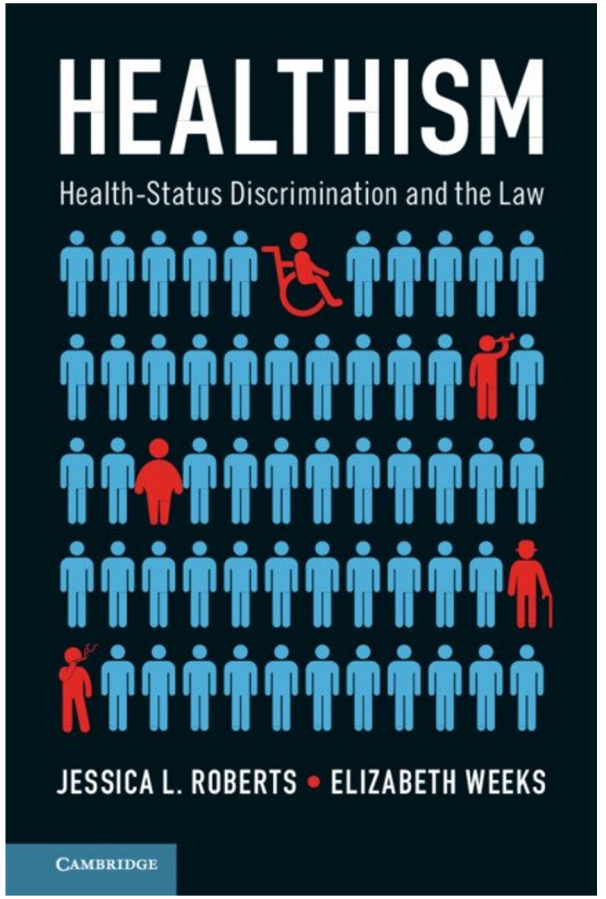
- The healthist approach lacks nuance
- Ignores the biopsychosocial approach to medicine/social determinants of health
- Overemphasis on personal responsibility: fails to account for a person's genetics, environment, socioeconomic status, ability/disability, and other intersections
- Colonial roots: ignores Indigenous health principles

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https://www.fnha.ca/wellness/wellness-for-first-nations/first-nations-perspective-on-health-and-wellness

Consequences of Healthism

- Discrimination and disadvantage based on health-related attributes
- Impulse to narrow a person's identity to a specific health marker (ie. "schizophrenic" or "diabetic") and not as whole people
- Negatively impact education, health care, public life, and employment
- Psychosocial implications: depression, anxiety, social rejection, suicide, avoidance of medical treatment, suicide, increasing unhealthy behaviours



Roberts, J., & Weeks, E. (2018). What Is Healthism? In *Healthism: Health-Status Discrimination and the Law* (pp. 1-22). Cambridge: Cambridge University Press. doi:10.1017/9781316675601.002

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Exercise – Diabetes Canada Weight Recommendations

1. For people with overweight or obesity who have or are at risk for diabetes, an interprofessional weight management program is recommended to prevent weight gain and improve CV risk factors [Grade A, Level 1A (24,28)].

2. Weight management medication may be considered in people with diabetes and overweight or obesity to promote weight loss and improved glycemic control [Grade A, Level 1A (42) for liraglutide; Grade A, Level 1A (45) for orlistat].

3. In adults with type 2 diabetes and overweight or obesity, the effect of antihyperglycemic agents on body weight should be considered when selecting pharmacotherapy [Grade D, Consensus].

4. Bariatric surgery may be considered for selected adults with type 2 diabetes and obesity with BMI ≥35.0 when healthy behaviour interventions with or without weight management medication(s) are inadequate in achieving target glycemic control or healthy weight goals [Grade A, Level 1A (58,59,61)].

Exercise – Diabetes Canada Weight Recommendations

1. For people with overweight or obesity who have or are at risk for diabetes, an interprofessional weight management program is recommended to prevent weight gain and improve CV risk factors [Grade A, Level 1A (24,28)].

- Sustained weight loss of ≥5% of initial body weight can improve glycemic control and cardiovascular risk factors.
- In people with diabetes and obesity, weight loss and A1C lowering can be achieved with healthy behaviour interventions as the cornerstone of treatment. Weight management medications can improve glycemic and metabolic control in people with diabetes and obesity.

Citation 24: Knowler 2002 - We will analyze
Citation 28: Look AHEAD Trial - 2010 results

24. Knowler WC, Barrett-Connor E, Fowler SE, et al. Reduction in the incidence of type 2 diabetes with lifestyle intervention or metformin. N Engl J Med 2002;346:393–403.

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Look AHEAD Trial Halted After Finding No CV Benefits of Intensive Lifestyle Intervention in Diabetes

Oct 15, 2012

ACC News Story

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The Look AHEAD trial has been stopped early due to lack of cardiovascular benefit, according to a statement released Oct. 19 from the National Institute of Health (NIH), the funders of the trial.

- Over 5000 participants, "Overweight" or "Obese" (avg BMI 36) with T2DM , must be < 75 yrs
- Intervention included calorie restriction (1200-1500 cal/day, max 1800 if > 250 lbs). < 30% calories from fat.
  - Initially, TWO MEAL REPLACEMENTS + one snack + one meal ("maintenance part" = 1 meal replacement)
  - Goal 175 minutes of exercise / week
  - If you don't lose enough weight, intensive counselling and then medications
- After 11 years of intervention (2001-2012), there was **no** difference in the primary endpoint of occurrence of Cardiovascular benefits
- Risks – no question on eating disorders or mental health
- Study is still often cited – they did ad-hoc analysis of the data after the study was stopped – showed improvement in **biomarkers**

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Break-out Sessions – 30 mins

The New England Journal of Medicine

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REDUCTION IN THE INCIDENCE OF TYPE 2 DIABETES WITH LIFESTYLE INTERVENTION OR METFORMIN

DIABETES PREVENTION PROGRAM RESEARCH GROUP*

Analyzing Weight-Centric Research:

- Question #1: Is the weight-loss group appropriately controlled?
  - No – there are many components to the lifestyle intervention, calorie restriction and exercise (150 min/week) and close follow up are grouped together
  - (note there are lots of studies of exercise alone showing benefits)

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Analyzing Weight-Centric Research:

- Question #2: Did they evaluate for risks or negative of the weight-loss intervention? If so, which risks or negative outcomes were tracked?

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Analyzing Weight-Centric Research:

TABLE 3. ADVERSE EVENTS.

EVENT	PLACEBO	METFORMIN	LIFESTYLE
Gastrointestinal symptoms (no. of events/ 100 person-yr)*	30.7	77.8†	12.9†
Musculoskeletal symptoms (no. of events/ 100 person-yr)‡	21.1	20.0	24.1†
Hospitalization			
One or more admissions (% of participants)	16.1	15.9	15.6
Rate (no. of admissions/100 person-yr)	7.9	8.4	8.0
Median stay (days)	3	3	3
Deaths (no./100 person-yr)	0.16	0.20	0.10

*Gastrointestinal symptoms included diarrhea, flatulence, nausea, and vomiting.

†$P<0.0167$ for the comparison with placebo.

‡Most participants with musculoskeletal symptoms had myalgia, arthritis, or arthralgia.

- (ative of the weight-loss comes were tracked?

- No monitoring of:
  - Psych (anxiety, depression) – impact on inter-personal relationships
  - Eating disorders
  - Discussion of harms of weight cycling on cardiovascular outcomes
  - Osteoporosis, gallstones

- (pg. 401)

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Analyzing Weight-Centric Research:

- Question #3: Is the methodology reasonable and culturally safe / appropriate? Does the methodology align with current nutrition recommendations for people at “normal” BMIs?
    - One of the better ones I’ve seen --> no meal-replacement shakes
    - Actually makes an explicit mention of being culturally appropriate
    - Large focus on “low-fat” diet to reduce calories – which is no longer recommended

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Session 1B: Getting Started Losing Weight.

To help you lose weight,
our goal is to help you to **eat healthy.**



Healthy eating involves **eating less fat.**

Eating too much fat is fattening (makes us fat) and is related to heart disease and diabetes.

The first step to eating less fat is to
figure out how much fat you are eating *now*.

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1. Plan ahead.



- Call ahead to ask about low-fat choices.
- Pick where you eat out carefully. Go somewhere that offers low-fat choices.
- Eat less fat and fewer calories during other meals that day.
- Eat a little something before you go out. Or drink a large, low-calorie beverage.
- Plan what to order without looking at the menu.
- Don't drink alcohol before eating.
- For parties or dinner parties: Bring something from home to share with others.

3. Take charge of what's around you.



- Be the first to order.
- Keep foods off the table that you don't want to eat.
- Ask that your plate be removed as soon as you finish.

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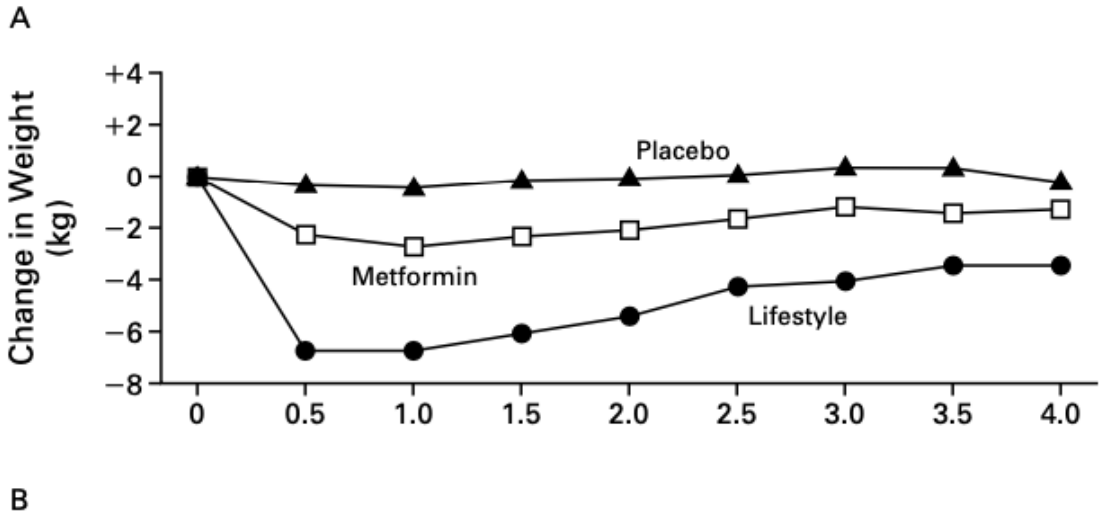
Analyzing Weight-Centric Research:

- Question #4: Are the measured outcomes clinically significant?
  - Standard + metformin 850 BID —> 7.8% incidence of diabetes
  - Standard + placebo —> 11% incidence of diabetes
  - Intensive lifestyle modification —> 4.8 % incidence of diabetes (although only ~ 1/3 had lost the goal 7% weight at the most recent visit …)
  - They didn't measure any other OUTCOMES (ie. besides A1C) – and we know in the Look AHEAD trial although biomarkers improve, it didn't change clinical cardiovascular outcomes

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Analyzing Weight-Centric Research:

- Question #5: Did the study include long-term data on the intervention?
    - Average 2.8 years – not bad
    - They report a 4 year graph – but only have half the participants at 4 years



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Analyzing Weight-Centric Research:

- Question #6: What is reported about dropouts?
    - 92.5% retention overall, but not broken down by group
    - Nothing reported about dropouts

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Analyzing Weight-Centric Research:

- Question #7: Does the conclusion naturally flow from the data without the *a priori* assumption that fatness is bad and weight loss is beneficial?

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Analyzing Weight-Centric Research:

- Question #8: Do the authors have conflicts of interest that relate to this article? If so, do they mention how those conflicts are mitigated?
  - Authors state no conflict

We are indebted to the participants in the study for their dedication to the goal of preventing diabetes; to Lipha Pharmaceuticals for the metformin and placebo; to LifeScan, Health-O-Meter, Hoechst Marion Roussel, Merck-Medco Managed Care, Merck, Nike, Slim-Fast Foods, and Quaker Oats for materials, equipment, and medicines for concomitant conditions; and to McKesson BioServices, Mathews Media Group, and the Henry M. Jackson Foundation for support services provided under subcontract with the Coordinating Center.

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Analyzing Weight-Centric Research:

- Question #9: Any other thoughts or comments on the article:

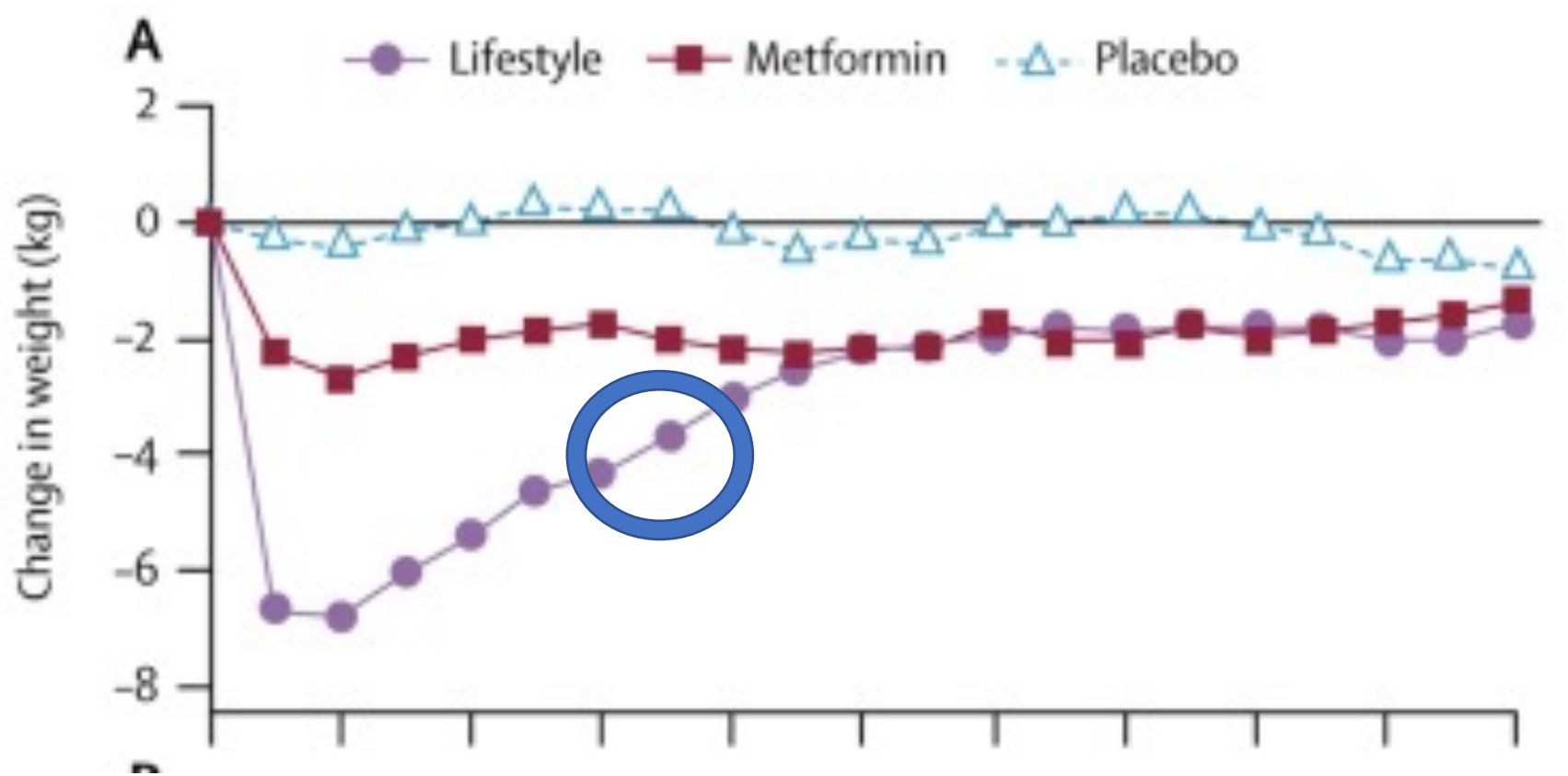
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Analyzing Weight-Centric Research:

- Question #9: Any other thoughts or comments on the article:
  - Both the current article and the Look AHEAD article had **more recent** publications … but they chose to cite the more PRELIMINARY studies that showed findings more in line with their recommendations

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Knowler article – 10 year follow up



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Look AHEAD Trial Halted After Finding No CV Benefits of Intensive Lifestyle Intervention in Diabetes

Oct 15, 2012

ACC News Story

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The Look AHEAD trial has been stopped early due to lack of cardiovascular benefit, according to a statement released Oct. 19 from the National Institute of Health (NIH), the funders of the trial.

Analyzing Weight-Centric Research:

- Question #9: Any other thoughts or comments on the article:
  - Though the guidelines have some nuance, in clinical practice we don't give patients a 16-week intensive course … we just tell them to lose weight (and then they are encouraged to pick up magazines like we saw at the start!)

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Reflection:

- Have you been in encounters where patients were encouraged to lose weight?
  - How did that go?
  - Was there any mention of the risks, or questions about what their current health behaviors are, or about a history of eating disorders?
- [if not in clinic, how about with yourself/friends/family/acquaintances who have tried lose weight?]
  - Have you noticed that their weight increases after dieting?

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Wrap up

- Today:
  - Argument supporting HAES
  - Unfortunately, this is where you are going to get stuck with many staff, patients, peers, and your own internal bias
- Next week:
  - Harms of weight-centric medicine and weight stigma
  - How to apply the HAES framework: case examples, various diseases, eating disorders

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Reflections? Questions?

Homework/Exercises

1. Notice one or two examples of weight-centric medicine in your lectures or clinical experiences:
    - Does the person cite their source or rationalize their approach?
    - Do they mention that there might be risks or situations where this is not valid?
    - Can you formulate an argument in your head (or out loud!) against their recommendation?

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Homework/Exercises

2. If on social media, follow 3 weight-inclusive / Fat Justice accounts
    - I will send an email with some of my favorites
    - Any suggestions welcome! Mention now or email me and I will add them

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Closing

- You are going to leave this two hours and go back into the weight-centric world – social media, medical lectures, in-clinic interactions
  - What thoughts and feelings come up when you encounter this? Does it make you doubt what you learned today? Can you make an argument for a HAES approach in these encounters – both to yourself and to others?
  - Be really kind to yourself!!! In the face of such a strongly weigh—centric society it is NORMAL to
    - Doubt HAES principles
    - Desire weight loss
- Mental health resources:
  - Physician Health Program 24-Hour Help Line 1-800-663-6729
  - Feel free to contact KW at: katarina.e.wind@gmail.com
- See you next week!!

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