

November 16th 2023

Dr. Katarina Wind

Weight Inclusive Care Workshop #2

Image: © Rohin Makkar & Dr. Katarina Wind 2023

Welcome Back!

- Reminders:
  - Triggers
    - Feel free to: Turn off your camera, take a break, leave
  - Confidentiality
    - Okay to share workshop content, personal reflections, KW and LE stories
  - Shame-free
    - We’re all unlearning anti-fat bias

Where did we leave off?

Why “Weight-Inclusive” Care?

- 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 often increases this “set weight”
  - People are not “overweight” / ”obese” because of poor dietary choices and lack of exercise
  - “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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Research report

Chocolate cake. Guilt or celebration? Associations with healthy eating attitudes, perceived behavioural control, intentions and weight-loss

Roeline G. Kuijer *, Jessica A. Boyce

Department of Psychology, University of Canterbury, Private Bag 4800, Christchurch 8140, New Zealand

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ABSTRACT

Food and eating are often associated with ambivalent feelings: pleasure and enjoyment, but also worry and guilt. Guilt has the potential to motivate behaviour change, but may also lead to feelings of helplessness and loss of control. This study firstly examined whether a default association of either 'guilt' or 'celebration' with a prototypical forbidden food item (chocolate cake) was related to differences in attitudes, perceived behavioural control, and intentions in relation to healthy eating, and secondly whether the default association was related to weight change over an 18 month period (and short term weight-loss in a subsample of participants with a weight-loss goal). This study did not find any evidence for adaptive or motivational properties of guilt. Participants associating chocolate cake with guilt did not report more positive attitudes or stronger intentions to eat healthy than did those associating chocolate cake with celebration. Instead, they reported lower levels of perceived behavioural control over eating and were less successful at maintaining their weight over an 18 month period. Participants with a weight-loss goal who associated chocolate cake with guilt were less successful at losing weight over a 3 month period compared to those associating chocolate cake with celebration.

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Body size as part of identity, not a disease

Image: @Fattiesandfeelings

Introductions + Reflection?

- Please introduce yourself (name / year / site / other info)
- 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?]
- EXTRA – What inspired you to join this workshop?

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Guest Speaker: Alexandra Shewan



Sky above Clouds IV, 1965
Georgia O'Keeffe

Today we will explore:

- Guest speaker!
- Harms of weight-centric care
- Health at every size:
  - What it is, what it isn't
  - Application to a patient case
  - How to create a weight-inclusive practice
- Workshops 3/4 – Eating disorders, diet drugs/bariatric surgery, HAES for specific disease (ex: diabetes, PCOS)

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So maybe the weight-centric evidence isn’t great…. But why is this so important?

The harms of weight-centric medicine

- Weight cycling
- Weight stigma
- Poor medical care
- Eating disorders (more in workshop 3/4)

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The harms of weight-centric medicine

Weight cycling

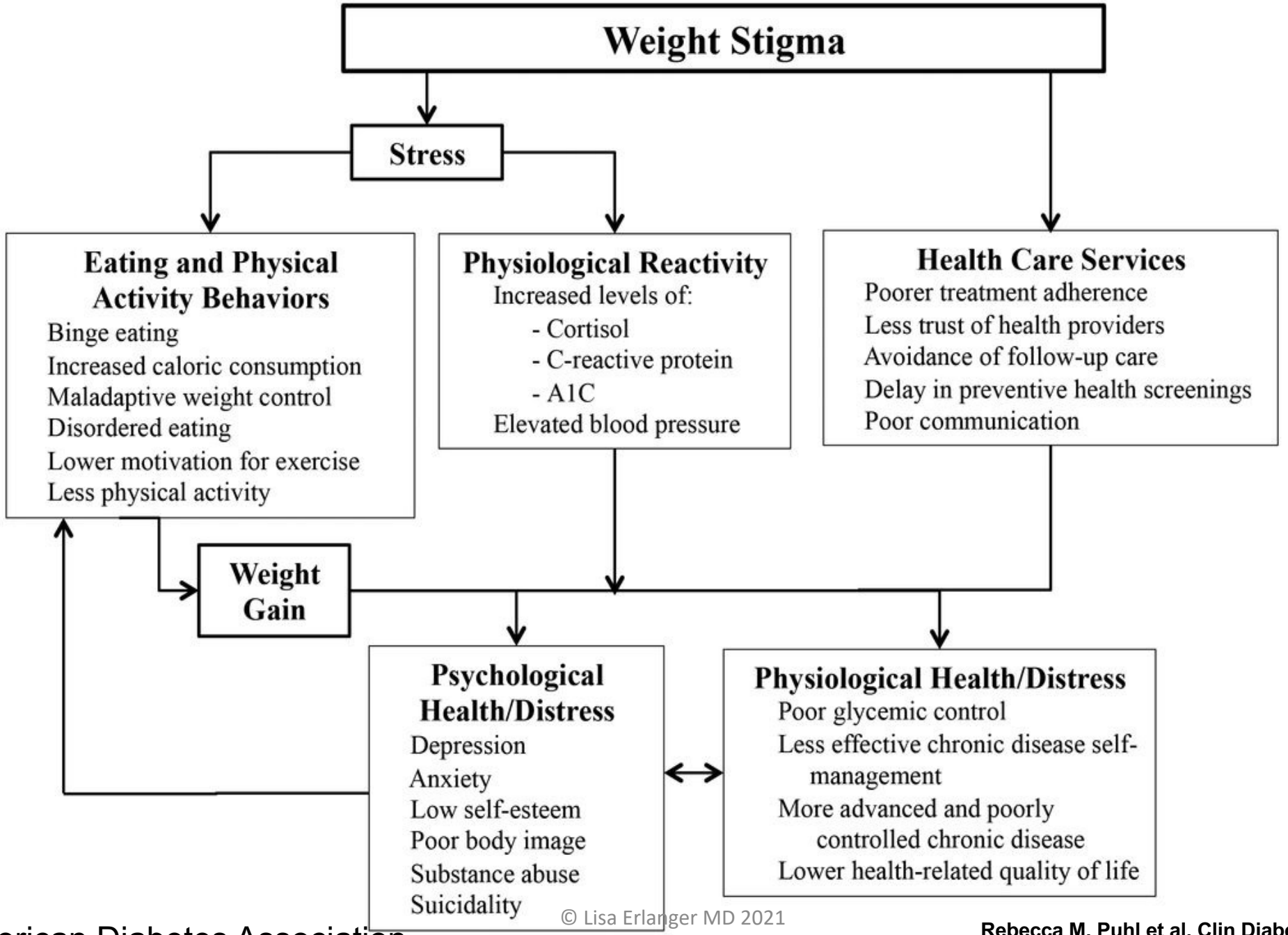
- Increased binge eating and weight gain
- Increased internalized and externalized weight stigma
- Increased medical complications:
  - Framingham Study (NEJM 1991)5000 people over 32 years:

    - weight cycling linked to both all-cause and CV morbidity and mortality
  - EFFORT (European Journal of Epidemiology 2007) 505 middle aged men across weight spectrum prospective x 15 yrs:

    - Weight fluctuations at any weight category- not weight category itself- predicted mortality. Stable obese not linked to higher mortality relative to stable nonobese
  - Tylka et al, 2014:

    - osteoporosis, gallstones, muscle atrophy, HTN, inflammation, RCC, endometrial cancer

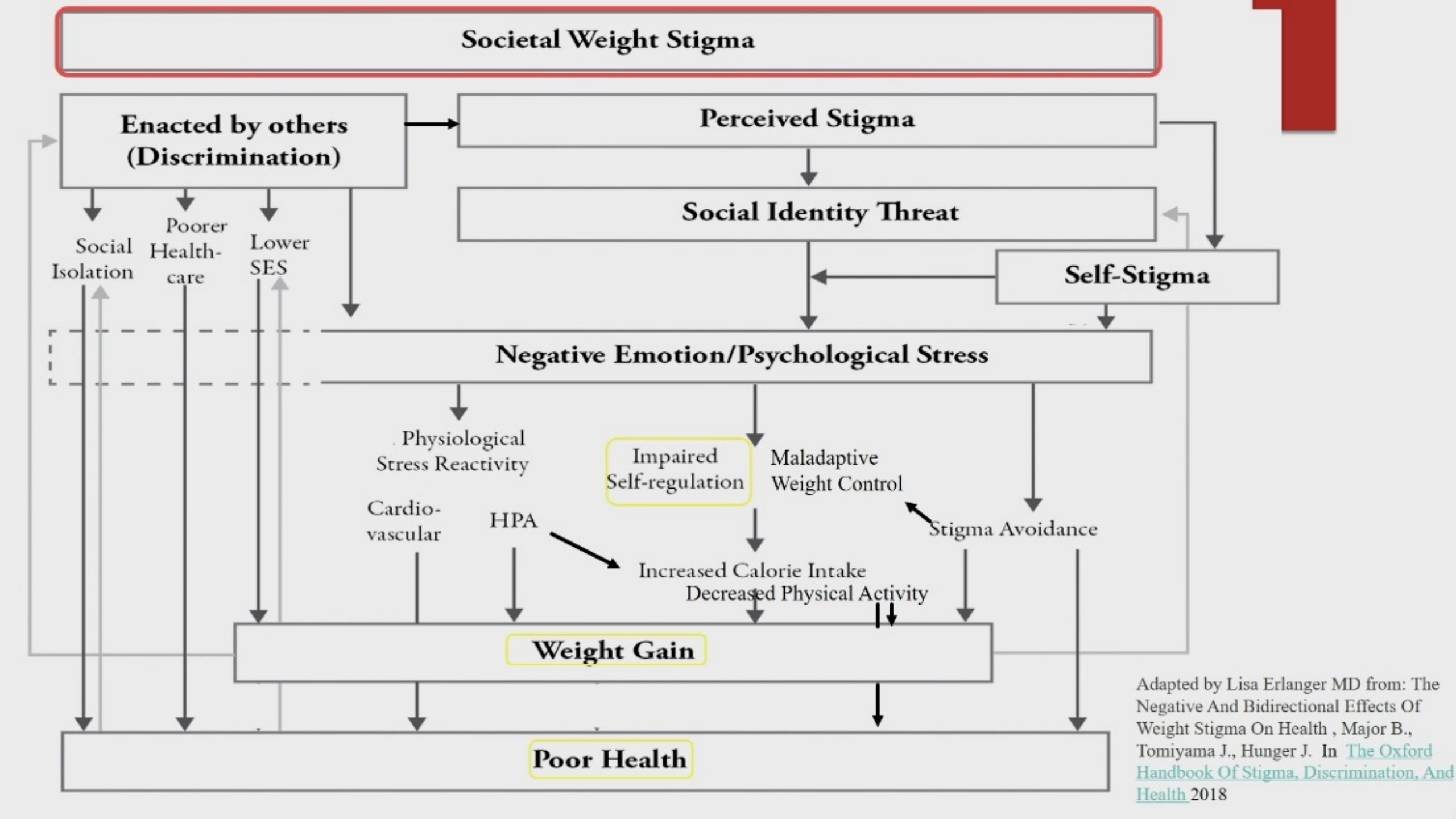
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Rebecca M. Puhl et al. Clin Diabetes 2016;34:44-50



Adapted by Lisa Erlanger MD from: The Negative And Bidirectional Effects Of Weight Stigma On Health , Major B., Tomiyama J., Hunger J. In The Oxford Handbook Of Stigma, Discrimination, And Health 2018

Weight is a major cause (sometimes top cause) of bullying in kids. This has worsened as we've medicalized "obesity".

Weight Stigma in Medical Treatment

- Delaying appropriate treatment for a trial of weight loss
- Choosing medications for appetite suppression
- Avoiding medications that cause weight gain
- Mentioning weight at every/unrelated visit
- Prioritizing discussion of weight
- Reluctance to exam, less eye contact, less time
- Weight data visible on all communication
- BMI cutoffs for fertility, OB, orthopedic, gender affirming surgeries
- Unproven diet recommendations or unrealistic weight/health promises
- Diet drugs, bariatric surgery – more in workshop 4

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Reflections? Questions?

First day on your 3rd year ED Rotation at VGH, and you pick up the chart for ….

Summer

35F

PMHx: “Obesity”, BMI 36

Prior surgeries: None

Meds: None

Allergies: None

- High school teacher, often will join in games while teaching PE
- Today twisted her knee in basketball, acute pain, “popping” noise, immediate swelling
- Presents to the ED

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Summer

35F

PMHx: “Obesity”, BMI 36

Prior surgeries: None

Meds: None

Allergies: None

In the ED:

- Only two narrow chairs with armrests remain in the waiting room, she doesn’t fit so she stands on one leg against the wall
- You have difficulty examining her larger legs. You aren’t quite sure if there is an effusion and aren’t confident about if the Lachman test is positive or not
- The XR returns negative so you send her home with instructions to take acetaminophen/ibuprofen
- As she is leaving your preceptor also suggests that she avoid sugary drinks and “junk food”, especially since she will be less active while her knee recovers

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Summer

35F
PMHx: “Obesity”, BMI 36
Prior surgeries: None
Meds: None
Allergies: None

Next three weeks:

- She struggles with pain and difficulty using crutches
- She notices ongoing instability of the knee when walking up stairs etc.
- She presents to a walk-in clinic
- The walk-in doctor notices instability on exam and refers her to orthopedics

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Summer

35F

PMHx: “Obesity”, BMI 36

Prior surgeries: None

Meds: None

Allergies: None

At the orthopedic office:

- No surgery for BMI > 35
- Plus, “It’s not as important for non-athletes”
- Recommends weight loss
- Suggests increased exercise plus a low carbohydrate diet, ”avoid sweets, sugary drinks, and junk food”, 1800 calories per day
- “It’s good we’re getting on this early, you are at high risk of diabetes and heart disease”
- Contact us when you’ve lost 20 lbs

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Summer

35F

PMHx: “Obesity”, BMI 36

Prior surgeries: None

Meds: None

Allergies: None

- What happens next:
- With “renewed motivation” she restarts dieting
- She is able to stick to the 1800 calorie recommendation for the next three weeks, although struggles with exercise due to her knee instability
- She starts losing weight, and is complimented by her co-workers and family. She is praised for her will-power when she doesn’t eat her own birthday cake
- Despite feeling tired and light-headed, she is so excited when she hits 180 lbs (20 lb loss), and gets to contact the orthopedic office for follow up

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Summer

35F

PMHx: “Obesity”, BMI 36

Prior surgeries: None

Meds: None

Allergies: None

- One evening a month later, she feels so hungry and ”caves” and buys a box of cookies. She has difficulty stopping once she starts and eats over half the box
- She feels disgusted with herself, throws the box away, and resolves to decrease her calories tomorrow to make up for it
- She skips breakfast the next morning, and eats a salad for lunch. But by the evening she is so hungry she again binges.
- This pattern repeats a few times per week over the next two months, until she has regained her original weight plus 5 lbs. She hasn’t been seen by the orthopedic surgeon yet and cancels her appointment because she knows she “failed” and is above the surgical cut-off.

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What to do instead?



Key reviews supporting wt inclusive care:

- 2013 - 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.
- 2014 - Tylka T, Annunziato R, Burgard D. The weight-inclusive versus weight-normative approach to health. J Obes. 2014;52(4):1–18. ***[ethical framework]***
- 2020 - Dugmore JA, Winten CG, Niven HE, Bauer J. Effects of weight-neutral approaches compared with traditional weight-loss approaches on behavioral, physical, and psychological health outcomes: A systematic review and meta-analysis. Nutr Rev. 2020;78(1):39–55. ***[meta-analysis]***
- 2022 - Mauldin K, May M, Clifford D. The consequences of a weight-centric approach to healthcare: A case for a paradigm shift in how clinicians address body weight. Nutr Clin Pract. 2022;37(6):1291–306.
- Key outcomes:
  - Biomarkers / health outcomes either improved or **unchanged** from wt normative approaches
  - Improved psychosocial well-being
  - Improved retention
  - Lessened eating disorders (ex: Bulemia)

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Bacon and Aphramor *Nutrition Journal* 2011, **10**:9
http://www.nutritionj.com/content/10/1/9

NUTRITION JOURNAL

REVIEW Open Access

Weight Science: Evaluating the Evidence for a Paradigm Shift

Linda Bacon[1*], Lucy Aphramor[2,3]

Abstract

Current guidelines recommend that "overweight" and "obese" individuals lose weight through engaging in lifestyle modification involving diet, exercise and other behavior change. This approach reliably induces short term weight loss, but the majority of individuals are unable to maintain weight loss over the long term and do not achieve the putative benefits of improved morbidity and mortality. Concern has arisen that this weight focus is not only ineffective at producing thinner, healthier bodies, but may also have unintended consequences, contributing to food and body preoccupation, repeated cycles of weight loss and regain, distraction from other personal health goals and wider health determinants, reduced self-esteem, eating disorders, other health decrement, and weight stigmatization and discrimination. This concern has drawn increased attention to the ethical implications of recommending treatment that may be ineffective or damaging. A growing trans-disciplinary movement called Health at Every Size (HAES) challenges the value of promoting weight loss and dieting behavior and argues for a shift in focus to weight-neutral outcomes. Randomized controlled clinical trials indicate that a HAES approach is associated with statistically and clinically relevant improvements in physiological measures (e.g., blood pressure, blood lipids), health behaviors (e.g., eating and activity habits, dietary quality), and psychosocial outcomes (such as self-esteem and body image), and that HAES achieves these health outcomes more successfully than weight loss treatment and without the contraindications associated with a weight focus. This paper evaluates the evidence and rationale that justifies shifting the health care paradigm from a conventional weight focus to HAES.

HAES / Weight-Inclusive Care Principles

- Recognizes the biases and harms of weight-centric care
  - Works to end weight-discrimination and stigma
- Centers the experience of the most marginalized, but is applicable to all bodies
- Supports people in finding **authentic motivation** and **sustainable methods** of caring for themselves, **regardless** of the weight (or specific health) outcome
  - Promotes autonomy
  - Let weight settle at set point
  - A person's healthy weight is the weight they are at when they are sustainably managing their wellbeing in their current context and within their current goals

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HAES / Weight-Inclusive Care does NOT mean

- That a person who desires weight loss is bad
- That weight loss is automatically unhealthy
- That health is within individual control
- That pursuing health is a moral imperative
- **Not only** an option for higher weight people that don't want or can't lose weight

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HAES / Weight-Inclusive Care – Lifestyle

- Intuitive Eating
- Joyful Movement
- Body Respect
- Stress, sleep, relationships, smoking, etoh
- Preventative health – vaccines, cancer screening etc
- Emphasis on managing medical conditions
- Acknowledgement of barriers – food insecurity, gym fat-shaming, lack of access to convenient options for movement and nutrient-dense foods
- No shaming, personal choice in priorities



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Evidence for **Health at Every Size (HAES)** Interventions

- Lower blood pressure
- More favorable lipids
- Increased exercise
- Less disordered eating
- Improved mood, self-esteem, body image
- Better adherence
- No weight cycling
- Greater resilience to weight stigma

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Tylka, et al The Weight Inclusive Vs Weight Normative Approach to Health. J Obesity 2014
Bacon and Aphramor. Weight Science: Evaluating the Evidence for a Paradigm Shift. Nutr J 2011

Thin Privilege in Medical Care

- I do not have to change my body in order to receive care (ex: surgical BMI cutoffs)
- My provider addresses my primary concerns
- I fit in the chairs, BP cuffs, and gowns
- I do not have to justify what I eat, I am not assumed to be lazy
- My medical symptoms are not blamed on my behavior
- There is not an automatic diagnosis for the size of my body
- I have my choice of reproductive options
- Medical staff are not repulsed by touching my body

Source: Lisa Erlanger MD 2021

Creating a weight-inclusive practice

- Adequate furniture and equipment
  - Chairs that are wider and/or without arm-rests , not flimsy
  - Beds, gowns, BP cuffs, etc.
- Size-inclusive images on walls, handouts, within providers
- Only starting with a weight when medically necessary
  - Ex: weight-based medication dosing, CHF
  - https://more-love.org/free-dont-weigh-me-cards/
- Language
  - Avoid: Obesity, overweight, normal weight, BMI
  - Use: First, do you need to comment on size? If yes: larger / smaller, straight-size / plus-size, fat, terms the patient chooses (ex: fat if they prefer)

Image: https://www.self.com/story/fat-people-societal-expectations

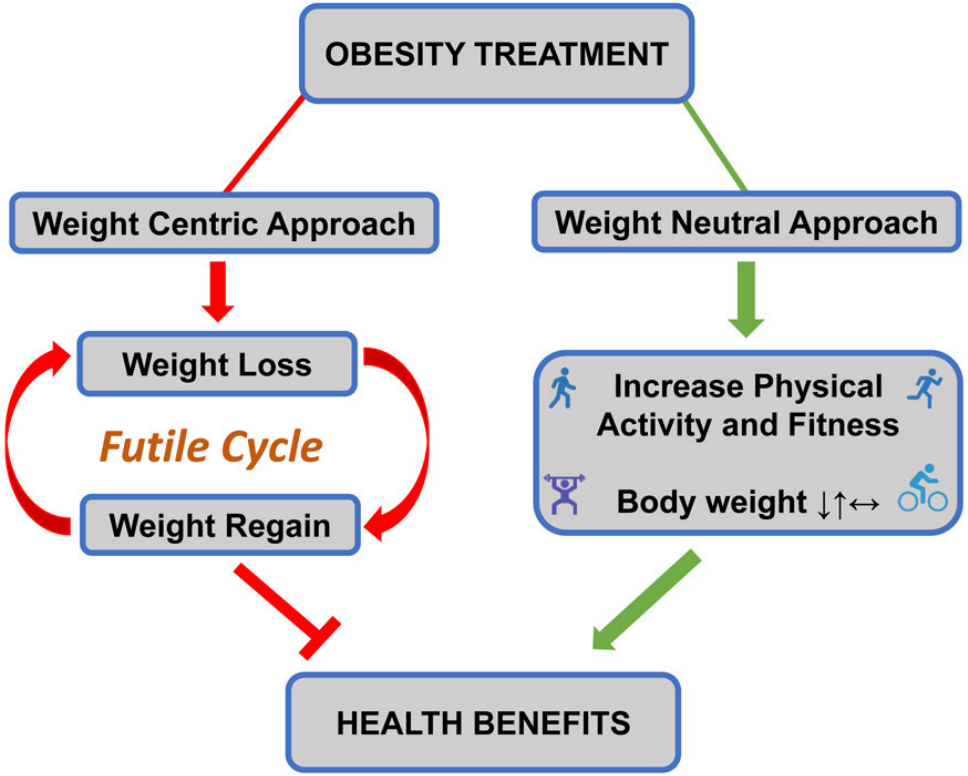
Source: Lisa Erlanger MD 2021

Creating a weight-inclusive practice - ctd

- Do not assume weight is the cause of the symptoms
  - If it is contributing, why now?
- Consider how you would treat a client in a smaller body with similar symptoms
  - Perform appropriate Pex and investigations as you would with a thinner person
  - Do not delay treatment for a trial of weight loss
  - Do not choose medications for their weight effects (+ or -)
- If discussing food or movement, link it to sustainable, evidence-based goals *other than* weight loss
  - Respect a patient's healthcare priorities
  - You have not "failed" lifestyle changes if you have not lost weight! You aren't "non-compliant"
- Screen for and treat health effects of stigma
  - Ex: Prior health care avoidance, shaming experiences by doctors, stigma present at work, gym etc

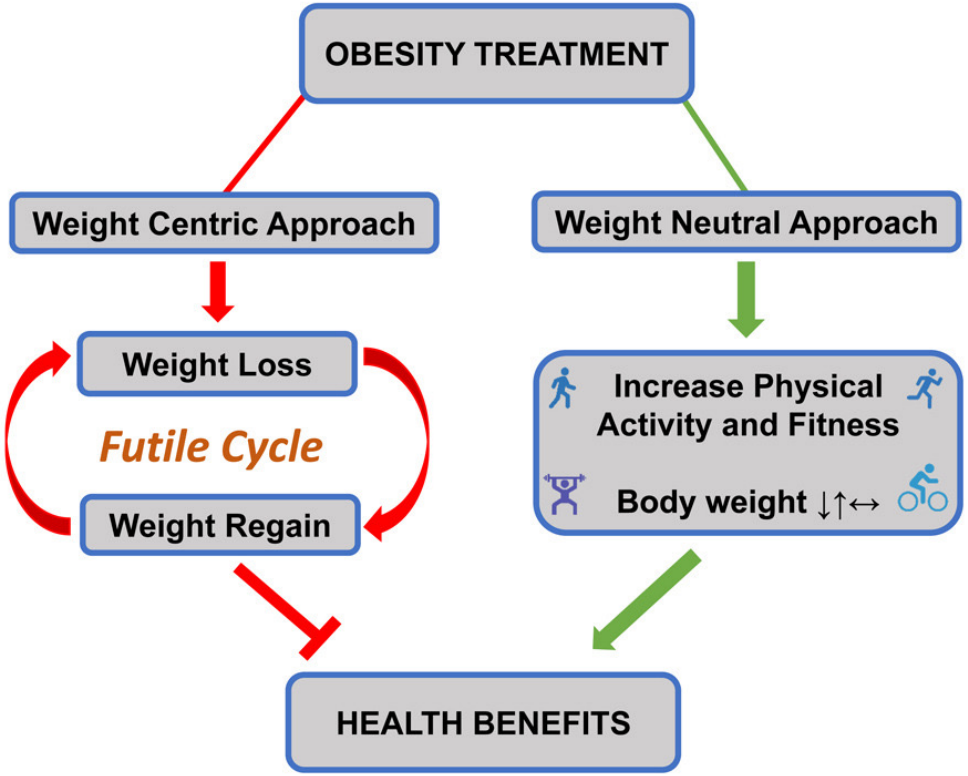
Creating a weight-inclusive practice - ctd

- Eating disorder screening, independent of BMI
  - For physical (constipation, dizziness) and emotional (depression, anxiety, food preoccupation) symptom
- If a patient wants to lose weight
  - Validate, not “bad” to want this
  - Screen for disordered eating
  - Inform about risks and lack of benefits of intentiona weight loss
  - I don’t have any evidence-based, harmless strategie help you
  - Redirect to HAES principles (intuitive eating, joyful movement, body respect)
- Weight-inclusive treatment of conditions
  - We will go over in detail



Creating a weight-inclusive practice - ctd

- Remove “Obesity” from list of medical conditions
  - “But what about cardiac risk stratification”? Can still mention dyslipidemia, HTN, diabetes, smoking status
  - This may not always be possible as a medical student
- Weight-inclusive treatment of conditions
  - We will go over in detail



Sometimes, you DO need to talk about body size – that's okay!!

- Medication dosing and delivery (ex: longer needles)
- Surgical planning (ex: special equipment for cesarean sections)
- MRI / CT scanners
- Congestive heart failure
- Acknowledging weight stigma (difficulty finding clothing that fits, chairs too small etc.)

- Don't give suboptimal care (ex: underdosing medication) due to a fear of acknowledging body size when it is **directly relevant**
- If needing to communicate this with other health professionals can use words like "larger bodied", and weight +/- height
- Communicate clearly the rationale behind weight in these cases
- If weighing patients, **use blind weights as the default**

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