Combating Bias to Promote Comprehensive Obesity Care for Older Adults

GSA Momentum Discussions Podcast from The Gerontological Society of America

This program is an addition to GSA's ever-growing body of work addressing the chronic disease of obesity, including *The GSA KAER Toolkit for the Management of Obesity in Older Adults.*

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Jen Pettis: Welcome to this GSA Momentum Discussion podcast episode, Combating Bias to Promote Comprehensive Obesity Care for Older Adults. Momentum Discussions highlight topics experiencing great momentum in the field of gerontology. My name is Jen Pettis. I am the Director of Strategic Alliances at the Gerontological Society of America or GSA. And I am delighted to serve as the host for today's Momentum Discussion. GSA appreciates Novo Nordisk's support of the GSA KAER Toolkit for the Management of Obesity in Older Adults and today's podcast. Please join me in welcoming today's guest and member of the expert advisory panel for the GSA KAER Toolkit for the Management of Obesity in Older Adults, Dr. Fatima Cody Stanford. Dr. Stanford is an Associate Professor of Medicine and Pediatrics at Harvard Medical School and an Obesity Medicine Physician Scientist at Massachusetts General Hospital. Dr. Stanford, thank you so much for joining me today and your willingness to share your insights around this important topic.

Dr. Stanford: Thank you so much for having me. It is a delight to be here.

Jen Pettis: Let's jump right into the conversation and start with talking about weight bias. In the GSA KAER Toolkit, we address weight bias and note that people affected by obesity feel stigmatized and are often reluctant to talk about their weight, much less agree to enter therapy for it. What exactly is weight bias and how prominent is it in the United States?

Dr. Stanford: Let's talk about weight bias and I'm going talk about two different types of weight bias. There's implicit versus explicit weight bias. Implicit weight bias is that weight bias you don't know you have towards individuals that carry excess weight. You are not aware of it. It's not something that's cognizant, something that you are acting on with kind of direct thoughts and emotions. Explicit weight bias is that bias that we do know that we have. An explicit weight bias is that weight bias that you might vocalize, and you might directly interact with individuals and express your disdain for them based upon their weight status. When we look at weight bias, we have these thoughts or attributes that we attribute to people that have excess weight that aren't found in any data. We may assume that someone that carries excess weight is undisciplined, passive, careless, or maybe they're nice. These attributes that we give to them because of what their weight status and what we feel that represents as it relates to those individuals.

When we look at weight bias, we have to recognize that weight bias is extremely prevalent here in the U.S. from us as healthcare providers, doctors and others, and also from our peers and our family groups, that we have a lot of weight bias. And I would say that it's one of the last acceptable forms of bias. If you think about your favorite comedy show or your favorite movies, many individuals that actually have excess weight may be making fun of themselves at the expense of themselves for the audience laughs. It's acceptable. It's encouraged. There are several different movies that we can probably think of, and shows that we can think of, where people that have excess weight are portrayed in negative and stigmatizing ways. Maybe we see them eating unhealthy foods or never exercising or being lazy. These things. The problem with this is that we then begin to attribute this to our friends and our families that may carry excess weight and then those ourselves that may carry this excess weight may feel as though we don't have the same value as individuals that are leaner. And that is just unacceptable. In terms of the medical profession, we see upwards of 90% of physicians and other healthcare professionals exhibiting bias towards patients that have excess weight. And this can be just as prevalent in the general population. This is highly prevalent and I would say highly unacceptable.

Jen Pettis: What are the consequences of weight bias?

Dr. Stanford: The consequences of weight bias are quite vast. Believe it or not, weight bias affects the health of an individual. When they experience weight bias, we can actually see physiologic changes in the body. What do I mean by that? We may see an increase in stress hormones like cortisol or C-reactive protein, hemoglobin A1C, which is your average blood sugar. And we may see increased blood pressure. These are actual physical changes that happen because a person experiences weight bias. But those are some of the physical changes. Let's talk about what may actually happen in terms of . see us in the medical system because they're experiencing such negative interactions in the healthcare setting. They may decide to withdraw from social interactions if they feel like if they go in a setting, they'll be judged based upon how they looked.

Many of these are psychological and have huge implications for that individual and goes all the way into older adulthood. I see individuals, I had a new patient actually, that came into me at the age of 87 last week. What she's experienced in her adult life, and we don't even have to go that far back. If we go back 20 years, she was 67 years old, still an older adult. And what she's carried with her and the language that she even used to describe herself had to do with, I think, the bias she's experienced from people like myself, doctors, and then her family that then perpetuates that she shouldn't be valued in the same way as someone that has a leaner body habitus. My goal, and particularly as a physician, is helping to undo and help people realize that regardless of their size, they're valuable and they should be considered in the same positive light that we do people with other chronic diseases.

Jen Pettis: You spoke about up to 90% healthcare providers having weight bias. What does weight bias then mean in healthcare overall? How does that impact the patients in the type of care they're getting? How does that really look in the healthcare situation from the patient's point of view, but from the system point of view as well?

Dr. Stanford: Let’s take it from the patient point of view, Jen, because I think that's a really, really important question. I'm going to show you how bias can show up in the healthcare setting. Let's say you're a person that carries excess weight and you go to the doctor. You usually go to the doctor, you check in at the receptionist desk, right? That's what we all do when we go to the doctor's office. Let's say you check in and you want to go have a seat to wait to go back because that's what we do. You realize that the seats aren't appropriately sized, meaning they have armrests that are very confining. You wouldn't be able to sit in the seat comfortably. Instead of you sitting in the seat, you choose to stand in the waiting room, you didn't really want to stand, but there's no choice in terms of finding a seat that's appropriate for you. You've received that first non-verbal cue that you don't belong in that setting. The receptionist gestures to you, “Hey, have a seat,” but you say, “oh, no, I'm going to stand.” Not recognizing, she's not recognizing him or her, they, them, theirs aren't recognizing that look, the seats aren't appropriate. Then you finally get taken back and you get taken back to have, let's say your blood pressure taken. And then when you have your blood pressure taken, you realize the cuff isn't quite appropriately sized enough. They're having a hard time getting a reading on your cuff because they're using an inappropriately sized blood pressure cuff. You've received, now, the second non-verbal cue that you don't belong in that setting. And let's say you now get on the scale and someone's kind of snickering, Maybe the assistant is snickering that the scale wasn't quite able to accommodate the number that you are. That’s the third non-verbal cue before you shave met the doctor. But let's get to that.

Then you get taken back into where you're going to wait for the doctor or other healthcare provider. And guess what? The exam table isn't quite appropriately sized, and they give you a gown that's much too small. You have a gown that doesn't quite cover me, you're pretty cold. You'd like to have a gown that covers you. Not really an appropriate seat, you choose to sit in the physician's seat because that's the only seat that you can sit in. The physician now walks in the room, how many cues have you received that you don't belong? Before the physician has the chance to say the first thing, which unfortunately often may be something stigmatizing, you've already decided this is not a warm and inviting place in many different ways.

Then you start talking to the physician and you know, the doctor says, you know, you really should work on your weight. And you as an older adult might think to yourself, “you know, doc, I've tried that.” And then the doc says, “Are you sure about that? What are you really eating? Are you really exercising? Are you sure?” What you've reported is being discounted as not the truth. Are you lying or are you just trying to give them an accurate representation of what your life has been as you've tried to navigate, maybe struggles with weight. Instead of being offered potential tools and strategies to help you, you've received a lot of negative feedback, both verbal and non-verbal, that what you say doesn't matter, must not be based in the truth. And guess what, your body doesn't matter in this setting either. This is how it shows up. I would say on the patient side of things, well, let's look at the system.

The system is, I would say, a big issue. And the way that we code our doctor's visits, a lot of the language we use in the ICD-10-CM codes is highly stigmatizing. We hear terms like morbid obesity. That's a very derogatory way to look at obesity. Do we call it morbid COVID-19? Do we call it morbid heart disease? Do we call it morbid diabetes? Do we call it morbid depression, which might lead to suicidality? No, we don't call it that, but we call it morbid obesity. The language we use matters, or there's an entire ICD-10 code which says excess calories due to overeating or something of this sort, do we really know? Or is it maybe they're a problem with storage or storage of too much adipose because of something going in the body?

The system is set up to make that person feel undervalued, like something is flawed within them. We often reinforce that by confining to rigid numbers and values that don't really apply to the person. For example, body mass index, which isn't derived for medicine or science, is the basis for how we evaluate weight and weight status. I would say that it's a good population-wide tool if I'm publishing a research study looking at thousands of people. But when I'm working with that person in front of me, is that the appropriate tool to utilize for that individual? And I would say that the resounding answer is, by itself, No. It is one of many tools that can help hone-in on what I need to do for that individual. The system has problems and then the individual patient and what they experience, their lived experience, can be set up in such a way that it creates a sense of discomfort and dis-ease. What does dis-ease lead to? It leads to disease and greater disease even as it relates to weight and weight status. That is how this is reflected at the patient level and at the system level.

Jen Pettis: You shared with me your 87-year-old patient came to your practice to address their body size. And thinking about that for older adults, they may have faced exactly that journey into the office that you just shared 1000s of times or at least 100s of times in their long lives. How is that going to impact their willingness to engage in conversation and seek treatment for the older adult in particular?

Dr. Stanford: That's the reason why I wanted to bring up that patient specifically. Well, first of all, I haven't had someone usually come to me for their very first appointment at 87, almost 88. Usually, we start in their sixties and seventies. But I think it says something really, really important. At 87 years old, this woman has decided now is the time. It may seem like late to others, but now she feels as though she's found someone that can help her address something she struggled with for a long time, her obesity and her other chronic diseases at 87. Now, what's interesting about this is that you are absolutely right. You said maybe 100s or 1000s of times they've had this negative engagement, which really makes people retreat from wanting to interact in the setting. But for this particular individual, she had heard me interview, she'd heard something, and she felt compelled to make this connection with me as an individual, feeling as though the judgment that she had faced that was often negative would not be the same in this situation.

And I wanted her to have the openness and willingness to talk about her lived experience for the last 87 years of her life and explain those points along the way where she may have retreated in terms of seeking the care she needed because of negative experiences she may have had both in the healthcare setting and from her friends and family. Now, one thing I can say, I'm not 87 years old, but I presume that once we're 87 years old, we've lived a lot of life and we've lost a lot, meaning lost a lot of loved ones. She's lost her husband and recently moved to the New England area to be with her daughter and then has some time for introspection. What does she want at this point in life? She's raised her kids, her grandkids are here, she's now focused on what can she do for her living her best life for the rest of her life.

And I think as older adults, that's the stage of life that you're at. You've lived life, you've often had children and grandchildren, maybe even great-grandchildren at this point. And what are you now going to do so that you live your best life? And she's decided that's what she wants to do. And she wants to do that in a caring and supportive environment, recognizing that some of those issues that may have happened early in life may have influenced her being where she is now. However, we can't go back. We have to move forward. Finding a good care environment is going to be key to helping that happen.

Jen Pettis: An individual's age and how they experience that weight bias over time is going to influence conversations. What other aspects of cultural identity influence weight bias experiences and patients' willingness to seek care?

Dr. Stanford: It is interesting that we have an emergence of fat acceptance health at every size movement that's very pervasive here in the US and much of our Western society and other countries that are Westernized. As I look at that communityand notice that there is some overlap in the work that I do as an obesity medicine physician. And there's one really major area of commonality, and that is that I believe that every single person should be valued regardless of their size. Wwhere we agree and where we diverge is that I recognize obesity to be a chronic relapsing, remitting multifactorial disease where genetics, environment, development, behavior, all play a role in a person's likelihood of having the disease. There are cultural implications and influences that may guide someone either towards or away from care.

When I'm working with an individual patient, I have to recognize what is the culture they're steeped in, what are their beliefs and lived experience and come to a shared decision making about whatever treatment or strategies is as appropriate. From a cultural perspective or even from how medicine views obesity, you know, we're very reticent to consider things particularly in older adults that we would otherwise. Now it's interesting, and I want you to think about yourself, if you're an older adult, how many have you or your friends gotten a total knee replacement or a total hip replacement or maybe had open heart surgery, these really big surgeries, and yet when I bring up bariatric surgery for an 80 something year old, people are like, “oh my goodness.” Now interestingly enough, the mortality rate for bariatric surgery is 0.07% lower than everything I just mentioned. But when I bring that up as it relates to treating obesity, it's like, “would you dare?”

But oh, let me go and get a new hip and a new knee, something that has a much higher mortality rate, much higher complication rate, much longer rehab time, and it's acceptable to do so. Indeed, this 87-year-old woman, when I really delve deep to like, why, why now? Why are you here? She needed a new knee. And her orthopedic surgeon told her she cannot get a new knee until she loses at least 10% of her body weight. In order to lose 10% of her body weight, we're obviously going to have to do a little bit more than lifestyle probably to generate that. Surgery probably would be a really great strategy for her because she has severe obesity, but she's accepting of the surgery to get the knee replaced and not so accepting of a much easier surgery that where she'll probably go home either that day or within a 24-hour period.

We, as a culture, have set up what's acceptable and not acceptable despite the safety profile of what I just mentioned. I have to recognize that. While I think, for example, for this patient that might be the best strategy is to go down a surgical pathway that's not part of that shared decision making, she's not quite there yet. I have to listen to where she is, come to terms with what that is and help guide her where she feels comfortable. I think that those influences are going to drive her and her interaction. And then of course, mine is going to be based in my experience caring for thousands of patients over time and looking at what I can do to have them live the happiest, healthiest life for as long as they can.

Jen Pettis: Well, I guess my last question here then is how do we fix this? How do we put an end to it in healthcare and in other aspects of our life?

Dr. Stanford: You know, I think this is going to sound like a very simplistic answer, Jen, but I think it's really the most important answer I can give you. And how do we fix this? I think it's as simple astreating others as we would like to be treated. What I'm sitting there caring for my patients, whether you're 87 or whether you're 7, care for all the people. I sit and think about “what would I want if I were sitting in the seat receiving the care?” If I am rendering care to that individual that is not exactly what I would want to receive and the compassionate caring way that I would want to receive it, then I am not doing my job. And I think as healthcare providers, whether we're physicians, nurse practitioners, PAs, physical therapists, exercise physiologists, the system, the CEOs, the chief medical officers, when we are guiding our decisions, we need to have that at the core of our decision making.

What would we want if we were on the other side? And if we can't say that we would be pleased with the care we're receiving, regardless of our disease state, then we are failing at the work we're doing from a systemic level, from an interpersonal level, and that's the way we solve it. But people have to

begin to think about how they want to be treated, the decision makers. And we have to start early because unfortunately, Jen, what we have to recognize is that we're dealing with older adults, but weight bias shows up approximately at 32 months of age. So, 32 months, you as an individual have decided what you believe about a person's value worth based upon their weight status. That means that for the older adults that are the grandparents, the great grandparents, you are influencing those little people that maybe you're helping to raise.

And people always will say to me when I mention that, “oh, you know, I don't say anything negative about larger people.” But it's also what you're not saying. Let's say you're watching television with your grandchildren and you mention positive things about people that are your Halle Berrys of the world and Gisele Bradys, and oh my gosh, look at how great they look. And you never comment negatively, but you also don't say anything at all about someone that may be of a larger body type. You are sending a message that they aren't stunning or whatever positive attributes you gave to that much leaner individual. Those little nuances are picked up in very young people that older adults are often having a large influence on. How older adults have lived with this for all of their life because it started early, whatever they were experiencing, particularly if they're someone that struggled early in life and then just continued to potentiate into older adulthood. So that's really how I think about this.

Jen Pettis: Well, this has been a terrific discussion, Dr. Stanford. Some things that I heard that really stuck out is the example that you talked about with the 87-year-old lady who's had that weight bias, but there's also a bit of ageism creeping in there, and I heard about obesity as a disease, and I think if we can shout that from the rooftops, that's certainly a long way to go. Your depiction of the patient's entry into the provider's office is a powerful, powerful example of perhaps implicit biased decision making for buying those chairs and things like that. And I heard you with the effects on health, the increased stress and higher blood pressure and all of those things. What are a couple key points you want to leave our listeners with?

Dr. Stanford: I think you did a good job, Jen, in capturing them, but let me see if I can leave a few key things. Number one, obesity is a disease, and it is not your fault. I don't think I specifically have stated it with those words, but I do want to state that now we believe obesity to be the fault of the individual. And as such, they should just live with the fact that they may be struggling and, and having difficulty navigating walking down the hall or up steps or whatever it might be because of this excess weight. And they just deserve that plight. And I would say that is indeed incorrect. It is a chronic relapsing, remitting multifactorial disease, and there are those of us that are willing and able to help you. If you've been struggling, and if you are now ready to take that step, find someone that can care for you.

Number two, how do you find that person? You know, you want to start with your primary care physician, and if you need more advanced help, much like the 87-year-old woman I just mentioned, you will see a specialist like myself. And how do you, how do you figure out how that who's, who's that person in your respective area? The American Board of Obesity Medicine has a free search tool where you can go to abom.org, that's the American Board of Obesity Medicine, and you can look in the top right corner for find a physician and verify credentials. And if you live in Kalamazoo, Michigan, you can type that in and see who's in your area if you want to find specialty care for the treatment of obesity. Number three, just because you're an older adult doesn't mean you can't receive care. You know, we're at a crucial point and we can optimize our health. And like I said, my goal is to get people to the happiest healthiest weight for them, not a particular number. Get that goal number out of your head. That's not what we're seeking. We do not care about how cute you look in your bikini or at your 60th class reunion.

That is not the goal we're going for. We're going for health, not aesthetics. If they happen to go together, fabulous, but that's not the overall goal.

And I would say the last thing I would leave is just give yourself some grace. If you, your family member, your good friend is struggling, give them grace. Give yourself grace. And if we do these things, we can navigate this disease in a loving, caring, and healthy way. And I think that's most important.

Jen Pettis: Well, thank you for your wonderful insights and for your time and for your ongoing support of GSA's obesity work. We are so proud of that work, and we're honored to have you as a part of it. And again, I want to thank our colleagues at Novo Nordisk for supporting us, and our listeners to our podcast episode. We hope that you enjoyed it. Thanks so much Dr. Stanford. Have a great day.

Dr. Stanford: Thank you so much, Jen.

Announcement: To learn more about the Gerontological Society of America, visit Geron.org. The Gerontological Society of America was founded in 1945 to promote the scientific study of aging, cultivate excellence in interdisciplinary aging, research, and education to advance innovations in practice and policy. For more information about GSA, visit Geron.org.