HEALTH CARE SYSTEMS PERSPECTIVES

Keith Norris, professor and executive vice chair for equity, diversity, and inclusion at the David Geffen School of Medicine at the University of California, Los Angeles, discussed the perspectives of health care systems on obesity and suggested how those perspectives could be improved going forward. He prefaced his remarks by defining three key terms:

- *Weight bias*: negative attitudes toward and beliefs about others because of their weight
- *Obesity stigma*: a social sign or label affixed to an individual who experiences prejudice because of excess weight
- *Weight-based discrimination*: enactment of weight bias and stigma in any discipline or sector

Norris continued by conveying the narratives about eating less and moving more are commonly heard by patients with obesity. To a patient, he pointed out, these narratives make weight loss and management sound simple, but they may also convey that health professionals believe obesity is self-imposed, so they have no obligation to help the patient find evidence-based treatments. In reality, Norris suggested, the journey for many patients has been anything but simple; he urged mindfulness of the challenges faced by people living with obesity.

To illustrate the reality of bias and stigma experienced in health care by patients with excess weight, Norris shared the results of a survey of more than 100 postgraduate trainees in professional health disciplines (Puhl et al., 2014). For example, 50 percent reported that their peers tend to have negative attitudes toward patients with obesity. However, only 1 percent agreed with the notion that if a person develops obesity, it is that person's own fault, so it is acceptable to make jokes about their weight, and just 3 percent agreed that it is acceptable to make jokes about patients with obesity. Yet despite the reportedly wide unacceptability of this behavior, Norris pointed out, other results of this survey indicate that it is pervasive in health care settings: 40–65 percent of respondents reported that they had heard or witnessed negative comments, jokes, or derogatory humor about patients with obesity from professors or instructors, health care providers, students, or residents. He added that about one-third of respondents said they felt frustrated with patients with obesity; a similar percentage expressed the view that patients with obesity can be "difficult to deal with"; and 13 percent reported a dislike for treating patients who have obesity.

With regard to respondents' perceptions of patients with obesity, Norris continued, 21 percent saw no difference between patients with obesity and those with normal weight; 18 percent stated the view that patients with obesity

tend to be lazy; 33 percent said patients with obesity lack motivation to make lifestyle changes; and 36 percent reported that patients with obesity are often noncompliant with treatment recommendations. On the other hand, Norris said it was encouraging that 95 percent of respondents said it is important to treat patients with obesity with compassion and respect, although only 27 percent reported that treating patients with obesity is professionally rewarding.

Finally, Norris pointed out what he characterized as a disconnect whereby 80 percent of respondents expressed confidence in providing quality care to patients with obesity, yet only 57 percent said they felt professionally prepared to treat patients with obesity effectively. These results have been replicated in a few other surveys of 600–800 providers, he added, referencing one survey in which physicians expressed their general sentiments that patients with obesity are noncompliant, lazy, lacking in self-control, weak willed, unsuccessful, and dishonest (Puhl and Heuer, 2009). These views, Norris said in summary, indicate how the health care system interfaces with many patients with respect to weight.

Norris observed that although physicians say they want to do the best for their patients, they may harbor implicit biases that hinder achieving that goal. He referenced research suggesting a high level of anti-Black implicit bias and a strong antifat bias among physicians and researchers (Alegria Drury and Louis, 2002; Merrill and Grassley, 2008). According to Norris, bias plays out in ambivalence about treatment roles, less time spent with and less discussion with patients, more ascribing of negative symptoms to patients, less intervention, and reduced preventive health services and exams (Puhl and Heuer, 2009; Sabin et al., 2012).

Biases among members of the health care system become embedded in the system's structures, Norris argued, and form weight-related barriers for patients navigating the system. He explained, for example, that patients with obesity may receive unsolicited advice about losing weight or inappropriate comments about their weight, or experience disrespectful treatment or inaccessible equipment and facilities because of their weight (Puhl and Heuer, 2009).

Norris reviewed the negative consequences of weight bias for patients, listing shame and guilt, anxiety, depression, poor self-esteem, and body dissatisfaction, all of which can lead to unhealthy weight control practices. He added that weight bias also negatively affects access to obesity treatment, educational attainment, employment opportunities, employment earnings, and quality of health care, ultimately leading to inequities in patient care (Puhl and Heuer, 2009). He explained that experiences of weight-based discrimination amplify psychosocial stress, which in turn triggers a reallocation of neuronal activity in the brain that leads to poor cognitive processing. For patients, he continued, this pathway initiated by structural biases can lead to suboptimal clinical outcomes as a result of internalized fear, shame,

guilt, poor self-esteem, anxiety, depression, mistrust of the health system, and inability to remember and implement health advice. Based on the way this bias operates, Norris maintained, health professionals tend to think of the patient and wonder, "What did you do to yourself?" A more appropriate question, he suggested, is, "What did society do to you?," which he said takes social determinants of health and structural biases into account.

Norris next offered strategies for countering bias and discrimination based on weight, starting with overcoming unconscious or implicit bias. Bias is universal and manifests differently for each person, he asserted, adding that recognition of one's potential for bias is a first step. He encouraged clinical settings to treat patients as individuals and with empathy, care, and respect instead of relegating them to particular categories to which labels and personal attributes are automatically assigned. To unravel the institutionalization of bias, Norris urged examining and revising health system policies and practices that perpetuate structural biases. He encouraged health care providers to recognize their roles as community resources and leaders for health equity. To not get involved is to choose to be passive, he stressed, which he equated with choosing to perpetuate structural biases and health disparities.

Norris urged that when caring for patients with excess weight, providers recognize their experiences with weight-related discrimination, weight bias–induced limitations on employment and educational attainment, mistrust of care, impaired cognitive processing from the additional psychosocial stress associated with their condition, and other comorbidities. What patients need, he stressed, is high-quality care, respectful treatment, empathy, compassion, support, and hope—not judgment, ire, or lecture. Such care builds trust, he said, and could reduce patients' psychosocial stress and resulting strains on cognitive processing. Norris ended his remarks with a quote from Sri Sathya Sai Baba: "Before you speak, think—Is it necessary? Is it true? Is it kind? Will it hurt anyone? Will it improve on the silence?"

PANEL AND AUDIENCE DISCUSSION

Following their presentations, the two speakers engaged in a moderated discussion and answered participants' questions. They covered the role of policy in addressing weight bias, medical education on caring for patients with obesity, sector-specific differences in the obesity wage gap, and worksite health promotion programs and weight stigma.

The Role of Policy in Addressing Weight Bias

Crespo began the discussion by asking the speakers to comment on the role of policy in addressing weight bias. Bevan replied that under