AUDIENCE DISCUSSION

Following Smith's presentation, Ard asked him whether different types of research and evidence need to be available before further childhood obesity recommendations are developed. Smith replied that although more evidence is desirable, it is unreasonable to wait for perfect data, and that failure to act on the available evidence would be a disservice to patients. Once a baseline of evidence for a particular intervention has been established, he suggested, the next step is to apply more robust and nuanced research methods to examine its effectiveness for various subpopulations and contexts.

Next, a participant asked Smith for his opinion on the potential for telehealth and remote patient monitoring to facilitate access to treatment. Smith maintained that telehealth is a key means of facilitating equitable implementation of childhood obesity counseling, particularly in rural locations that lack obesity specialists. He observed that the COVID-19 pandemic had improved people's comfort and familiarity with telehealth modalities.

Another participant asked whether shared decision making could help bridge the gap between an evidence-based recommendation that seems unattainable and the need to act. Smith wholeheartedly agreed that shared decision making is a good alternative in these cases. A benefit of shared decision making is being able to engage more deeply and meaningfully with patients, he added, which enables a shared understanding of the kinds of common-sense solutions that can be pursued when the optimal solution is inaccessible.

THE EFFECT OF OBESITY ON PATIENT–PROVIDER COMMUNICATION

Kimberly Gudzune, medical director of the American Board of Obesity Medicine and director of the Healthful Eating, Activity & Weight Program at The Johns Hopkins University, reviewed evidence on how health care professionals' attitudes, communications, and behaviors may differ for patients with obesity and proposed potential strategies for improving these patients' health care experience.

Gudzune began by observing that multiple challenges to obesity care exist in health care settings. She cited the examples of incomplete insurance coverage for evidence-based treatments (e.g., behavioral weight-loss counseling, antiobesity medications, bariatric procedures) and medically induced causes contributing to obesity or impaired treatment (e.g., medications that promote weight gain) (Apovian et al., 2015; Kushner, 1995; Tsai et al., 2006).

The physical environment of a clinic may propagate stigma, Gudzune continued, if appropriately sized equipment and devices are unavailable to accommodate patients of all sizes. Although subtle, she said, such environmental factors can signal to patients with obesity that they are unwelcome and unable to be treated. As another challenge she pointed to clinicians' lack of time to perform obesity care services—assuming they are even trained to provide them—as well as a broader problem of clinicians themselves serving as a source of stigma for patients with obesity (Gudzune et al., 2012; Kushner, 1995; Mastrocola et al., 2020; Puhl and Brownell, 2001).

Gudzune elaborated on clinicians' biased attitudes toward patients with obesity, which she characterized as pervasive and persistent over time. According to surveys conducted on different continents as far back as 1969, she reported, clinicians associate obesity with poor hygiene, lack of adherence to recommendations, and dishonesty. Primary care physicians tend to believe that patients with obesity are less likely to follow medical advice, benefit from counseling, or adhere to medications, attitudes that Gudzune suggested may subtly influence their treatment recommendations (Foster et al., 2003; Hebl and Xu, 2001; Huizinga et al., 2009, 2010; Klein et al., 1982; Maddox and Liederman, 1969; Puhl and Heuer, 2009).

Gudzune maintained that in the context of these challenges, patients with obesity often have health care experiences that can negatively affect the treatment they receive. She gave several examples of these negative effects, beginning with patients' avoidance of or delay in health care seeking. One study found that more than half of patients with obesity reported canceling an appointment because of anxiety about being weighed (Alegria Drury and Louis, 2002), Gudzune relayed, while another study found that patients with obesity delayed cancer screening tests because they feared being treated disrespectfully or otherwise stigmatized (Amy et al., 2006). In many cases, she added, patients with obesity have higher risks for adverse health outcomes, which heightens the importance of their prompt engagement in care.

A second example of these negative effects, Gudzune continued, is impaired continuity of care. Patients with obesity are 37 percent more likely to "doctor shop," she reported, noting that some people engage in doctor shopping as a result of weight-stigmatizing experiences, such as the perception that their primary care provider has judged them on the basis of their weight (Gudzune et al., 2014b). They also have a 68 percent greater incidence of going to the emergency department although they are not at increased risk of hospitalization (Gudzune et al., 2013), which according to Gudzune indicates that they are accessing the emergency department for concerns that instead could have been brought to a primary care provider if they had a continuous relationship with one. Gudzune stressed how important it is for providers to understand a patient's prior experience with

weight stigma in health care settings so they can promote a welcoming environment that fosters continuity of care.

Gudzune moved on to a third example—undermining communication—which she described using data comparing incidence rates of physician communication behaviors (during typical primary care visits) with patients who have overweight and obesity and those with normal weight. These data showed nonsignificant differences by patients' body weight for medical data gathering (e.g., collecting information about medical history) and education/counseling (e.g., how to take a medication), as well as data gathering and education/counseling on lifestyle topics. Gudzune questioned the equitability of the counseling outcomes, however, given that patients with overweight and obesity may warrant more counseling, particularly for lifestyle behavior changes. Among patients with versus those without overweight or obesity, she highlighted a significantly lower incidence of physicians' emotional rapport building (e.g., developing a connection between patient and provider, including exhibiting empathy, which Gudzune identified as critical for successful behavioral counseling).

As a fourth example Gudzune cited the influence of a patient's weight on a clinician's decision making and care. Gudzune pointed out that clinicians may avoid performing exams for patients with obesity if they encounter technical difficulty or lack the proper equipment, adding that diagnostic plans may differ for patients with versus those without obesity (e.g., physicians tend to prescribe more tests and to spend less time in the room with these patients) (Campbell et al., 2009; Ferrante et al., 2006; Hebl and Xu, 2001). This differential treatment extends to clinicians' lower likelihood of counseling patients about weight loss, she continued, for such reasons as perceiving limited efficacy or futility of obesity treatment, feeling unprepared with respect to training, having limited time and reimbursement for services, and ranking weight-loss counseling low on the list of multiple issues to address during a care visit (Fogelman et al., 2002; Foster et al., 2003; Gudzune et al., 2012; Kristeller and Hoerr, 1997; Kushner, 1995).

Lastly, Gudzune mentioned effects on patient outcomes. She shared one example in which lower rates of cancer screening (mammography, pap smear, colonoscopy) were observed for patients with overweight or obesity compared with those with normal weight. She added that greater degrees of obesity were associated with lower rates of screening (Maruthur et al., 2009a,b, 2012).

Gudzune shifted to highlighting opportunities for clinicians and health care settings to play a positive role for patients with obesity. Among participants in a behavioral weight-loss trial, she reported, higher ratings of the helpfulness of the primary care provider's involvement were associated with greater weight loss in primary care, as was combining population health management with an online obesity care program. She added that

discussing weight loss with patients in a way that they do not perceive as judgmental is associated with achieving clinically significant weight loss over 1 year, and that, contrary to some assumptions, non-Hispanic Black, Hispanic, and Asian patients want to have weight-related discussions with their clinicians (Baer et al., 2020; Bennett et al., 2015; Gudzune et al., 2014a; Lewis et al., 2016).

Gudzune pointed out that evidence-based communication and counseling approaches such as the 5A's framework and motivational interviewing are associated with improvements in patient willingness and confidence with respect to changing their health behaviors, and are applicable in a variety of clinical settings (Alexander et al., 2011; Cox et al., 2011; Gallagher et al., 2021; Jay et al., 2010, 2013; Pollak et al., 2010; Washington Cole et al., 2017; Welzel et al., 2021). She suggested that, because clinicians can readily be trained in these techniques, and many clinicians may already be familiar with them, their regular use could change care for patients with obesity.

Gudzune ended her presentation with a list of ideas for addressing weight bias in health care settings, with the caveat that most are untested yet pragmatic based on relevant available evidence. One is to alter the clinic environment to provide chairs and medical equipment that can accommodate patients of any size, which she said could be facilitated by providing financial support or incentives for facilities to cover the expenses involved. Another idea, she suggested, is to provide sensitivity training to improve awareness of how clinician attitudes can impact patients with obesity, in combination with additional research to design and evaluate such trainings. A similar idea, she continued, is to increase empathy and positive affect among clinicians through perspective-taking exercises, and another is to increase their awareness of weight bias and help them examine their explicit and implicit attitudes (Alberga et al., 2016; Phelan et al., 2015). Gudzune added that interventions to address clinician barriers might include providing education—from medical school through board certification and in continuing medical education—on the multifaceted contributors to weight gain and loss; conducting training on evidence-based counseling techniques; leveraging electronic health records to support counseling; and improving access by advocating for coverage of evidence-based obesity treatments with insurers, employers, and government agencies.

AUDIENCE DISCUSSION

Gudzune answered a few questions following her presentation. First, Ard asked how race concordance affects patient–provider discussions about obesity. Gudzune responded by explaining that race concordance can be an important factor in how conversations play out; for example, having race