

Direct and Compassionate Communication: A strategy for counteracting weight-related bias in healthcare

By Serena Roschman

Numerous studies confirm that health care providers (HCPs) harbor both implicit and explicit bias toward their overweight and obese patients (Sabin et al., 2012). This bias contributes to lower engagement in self-care and preventative care and intelligent communication is key to reversing this trend (Kahan, 2018). After considering the research related to weight-related bias, this paper will argue that if patients are engaged with direct yet compassionate communication, their health outcomes could improve substantially.

Evidence of Bias

Our first question must be: Is there evidence of a bias against the overweight on the part of HCPs? In this area, most recent literature seems to agree that the bias HCPs hold toward this population is similar to the bias that the overweight experience from the general population (Sabin et al., 2012). In real-life experience, this amounts to about one instance of bias per day as they interact with the world (Vartanian et al., 2018).

When testing doctors directly using both implicit and explicit bias measures, Sabin et al. (2012) found that doctors have both a strong implicit (unconscious) and explicit (conscious) negative bias toward those who are overweight. A study by Forhan, Risdon & Solomon (2013) indicated that primary care providers (PCPs) report that the higher the patient's body-mass index (BMI), the lower the respect they have toward the patient. In fact, over 50 percent of the MDs studied admitted to associating obesity with laziness and incompetence (Forhan et al., 2013).

Tomiyama et al. (2018) speculated that the prevalence of bias toward the obese outpaces even the well-established bias based on race.

Effect of Bias on Patient Engagement in Health-Promoting Behaviors

If we consider patient engagement to be the degree to which patients take an active role in their health and healthcare, there is evidence that the bias against those with obesity decreases the patient's commitment to their own health (Tomiyama et al., 2018).

From the patient's perspective, feeling shame based on their weight leads to poorer health decisions, including eating more, exercising less, and increased use of alcohol (Tomiyama et al., 2018). Vartanian et al. (2018) found that after each instance of perceived weight-related bias, the patient was more likely to engage in binge eating and generally have lower motivation for health-promoting behaviors such as exercise. Further, Forhan et al. (2013) found that patients with obesity feel concerned that their provider will attribute all of their health complaints to the fact of their weight. Logically, we could hypothesize that this perception of bias explains some of the obese population's avoidance of medical treatment and non-compliance with medical recommendations (Forhan et al., 2013).

Effect of Bias on Patient-Engagement on Preventative Care

Obesity is now recognized as a complex medical condition that requires ongoing preventative care to avoid exorbitant cost, suffering, and mortality. In the last decade (starting in 2011), Medicare began covering obesity treatment, a strong indication that health policymakers see preventative care as essential for patients with obesity. Still, this billing code remains underutilized, removing high cost and low reimbursement as potential causes for this lack of engagement (Kahan, 2018). Given this fact, the research surrounding this population's

engagement in preventative care is even more sobering. Though the cause is likely complicated and multifaceted, bias on the part of HCPs certainly bears responsibility. Let's examine two specific conditions: pediatric care and cancer screening in women.

Hampl et al. (2011) looked at the completion of care programs in pediatric obesity clients and found that a majority of clients do not complete the recommended treatment---an indication of low patient engagement. Further distressing is that the most disadvantaged patients are most likely to quit treatment, including those on Medicaid and those in minority populations. Patients that experienced depression and low self-worth were also at an increased risk of abandoning their care (Hampl et al., 2011). Thus, those patients already at high risk for both health complications and low engagement are somehow being discouraged from interacting with the medical system. Given Sabin et al.'s findings that (2012) only 5 to 33 percent of doctors feel competent to treat obesity in children, we can reasonably conclude that this vulnerable population does not get equal care.

Cancer screening for women is another area of medicine that reveals weight-related bias. The research of Wee et al. (2000) began with the question of why obese women are less likely to receive preventative cancer screening than their non-obese counterparts. Even after adjusting for other factors such as access to care, education, and so forth, Wee et al. (2000) found that doctors were less likely to perform routine pelvic exams and other screenings on obese women *and further*, obese women were less likely to ask for such screenings. Given that Wee et al. (2000) were able to adjust for other factors, this research provides a compelling argument for weight-related bias decreasing patient engagement.

More Patient Engagement Equals Better Outcomes

We might now ask the question: does it matter? Does a softening of harsh weight-related bias increase engagement? Does an increase in patient engagement lead to better health outcomes? Perhaps in part due to their previously established bias, there seems to be a reluctance on the part of HCPs to diagnose and treat obesity directly and comprehensively. Further, when HCPs don't mention obesity as a concern, patients often assume it is not an issue, often leading to lower engagement in health-promoting behaviors (Kahan, 2018).

In contrast, when PCPs counsel on obesity as a medical condition, patients are more likely to engage in healthier eating, exercise, and lose four times more weight than those whose obesity is not addressed directly (Kahan, 2018). These results are backed up by a number of researchers in different settings. A fascinating study by Bennett et al. (2012) found that tailoring health goals and behavior interventions for clients via an electronic method resulted in modest weight loss for vulnerable, disadvantaged populations. The mechanism of daily health reminders increases engagement, and the improved health outcomes indicate the importance of this factor in better health outcomes (Bennett et al., 2012).

The Role of Health Communication in Improved Engagement of People with Obesity

Finally, let's turn to the question of how health communication can impact this problem. We have already established that not communicating about obesity leads to poor engagement and outcomes (Kahan, 2018). At the same time, stigmatizing or shaming patients around their obesity *also* leads to poor engagement and outcomes (Tomiyama et al., 2018). Thus, communication must be an intelligent combination of direct, empowering, and compassionate.

Forhan et al. (2013) comes to a similar conclusion and asserts that a trusting relationship with a HCP is key for the long-term effective management of this complex condition. Let's

consider what builds trust in such a relationship: First, it seems essential that physicians are educated about their bias and its role in engagement and subsequent outcomes. Recognizing and receiving counseling around checking their bias seems like an essential first step toward fostering the type of compassionate communication required to build trust.

Stigma creates a veil that blinds the provider to the individuality and humanity of the patient. Intelligent health communication can compile the related research and best practices for providers. Then, providers might be more likely to engage patients in care in a direct and compassionate manner. Such engagement is more likely to affect behaviors and the sense of self-efficacy required to make the challenging lifestyle changes for a healthier life.

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