Weight of Inequity: Addressing Social and Structural Barriers in Bariatric Surgery

CMEO Podcast Transcript

Monica E. Peek, MD, MPH, MSc:

Hello, I'm Dr. Monica Peek, and I'd like to welcome you to *Weight of Inequity: Addressing Social and Structural Barriers in Bariatric Surgery*. This case-based CME activity is supported by an educational grant provided by Johnson & Johnson. During our discussions today, we'll disclose if any therapies or procedures mentioned are off-label or investigational. So, again, my name is Dr. Monica Peek. I'm the Ellen H. Block Professor of Health Justice and I'm also the Vice Chair for Diversity, Equity, and Inclusion in the Department of Medicine at the University of Chicago. I've been a primary care physician for more than 20 years, and I treat patients with a range of chronic diseases including obesity. I'm thrilled today to be talking about management strategies for obesity, and I'm pleased to be joined by two of my very distinguished colleagues whom I'm going to ask to introduce themselves. And I'll start with Dr. Husain.

Farah A. Husain, MD, FACS, FASMBS:

Hi, everyone. I'm Farah Husain. I'm a professor in the Division of Foregut and Metabolic Surgery, and the Vice Chair of Education at Oregon Health and Science University, where I also serve as the Program Director for our general surgery residency. I have practiced metabolic and bariatric surgery now for 19 years, and I'm very excited about being a part of this discussion today.

Monica E. Peek, MD, MPH, MSc:

Great. And Dr. Salles?

Arghavan Salles, MD, PhD:

I'm Arghavan Salles. I am trained as a bariatric surgeon, and also do work in social science and so I've done a lot of work on implicit bias in different realms including obesity. I'm really delighted to join this conversation. As far as where I sit, I currently am Clinical Associate Professor of Medicine at Stanford University.

Monica E. Peek, MD, MPH, MSc:

Great. Stanford's one of my alma maters. I always love that place. All right, I am thrilled to have you both with me today to be talking about this issue. This is a disease that affects so many Americans, and your expertise is really going to be wonderful. I'm really looking forward to our conversation today. We have several learning objectives. After participating in this activity, our audience should be better able to do several things. First, assess the impact of implicit bias and structural inequities on referral patterns, access to bariatric surgery, and post-operative outcomes across diverse patient populations. And then second, to implement evidence-based approaches to reduce disparities in bariatric surgery.

By way of introduction, we can see that 40% of adults in the United States are living with the disease of obesity. That is almost half of us. Ten percent of Americans have Class 3, or what we call severe, obesity. Associated comorbidities are things that I treat every day as a primary care physician, such as hypertension, type 2 diabetes, high cholesterol, heart failure, osteoarthritis, cardiovascular disease, not to mention gallstones, and a range of

other things, and cancers. I didn't really realize how many different cancers were associated with obesity. It is a chronic disease that is driving a lot of our other chronic diseases that are causing a lot of morbidity and mortality for our patients, and escalating health care costs as well. So, Dr. Husain, can you provide a little bit of a background for us about how bariatric surgery can address some of the problems?

Farah A. Husain, MD, FACS, FASMBS:

Yes, of course. Bariatric surgery now is often referred to as metabolic and bariatric surgery, so you may see that term being used quite a bit as we've come to understand more about obesity being a chronic disease and a disorder and how metabolism may work. The most important thing that many patients will ask first is, Is it [bariatric endoscopy/surgery] a safe treatment? We do stress that it is a very safe treatment. It's very effective and has durable results. There are a lot of newer procedures in addition to very old procedures being done now, and all of them have shown quite safe efficacy across the board. With these procedures, you do expect them to have improvement in both health outcomes and quality of life to be effective surgeries. Bariatric endoscopy is a newer field. It's where we use a special scope to adjust things within the stomach, and that can include placing intragastric balloons, or doing something called an endoscopic gastroplasty where we actually sew the stomach from inside of it.

Bariatric surgery, again, also known as metabolic surgery, includes things like your sleeve gastrectomy, Roux-en-Y gastric bypass, and biliopancreatic diversion with duodenal switch. In this next image you'll see pictures of these representative surgeries. These surgeries are complicated on the inside but done with small laparoscopic or robotic incisions. On the outside, a lot of times that looks similar to gallbladder surgery or appendix surgery, but on the inside I'll start with the sleeve gastrectomy because that's the most commonly done procedure across the world. We remove about two-thirds of the stomach in the sleeve gastrectomy and make your stomach more the shape of a tube, or it's a sleeve shape, which is why it's called that. The Roux-en-Y gastric bypass has been done since the 1960s. In this procedure we create a small stomach pouch that's about the size of the palm of your hand, or 4 ounces, and we connect that pouch to your intestine bypassing a section of your intestine that is heavy in absorbing fats and sugars.

The adjustable gastric band is still listed on this because it is done in other parts of the world, but it's not really done in the United States anymore. We consider it more historic. However, there are patients who may have it placed, and many tourism-type cases where they're going to Mexico, et cetera, or there may be patients who have the band now and want to have information about this as well. We'd like people to know that that's where a plastic or silastic instrument that is placed around the stomach with the idea of creating an hourglass squeeze on the stomach to let it slowly empty. And then there's the biliopancreatic diversion with duodenal switch, or what I like to call the DS, or there's the single anastomosis duodeno-ileal bypass with sleeve gastrectomy (SADI-S) which is a newer procedure. It was done originally in the 1970s. It had some outcomes that weren't great back then, and that was when we really didn't work with patients as much, quite honestly, and give up enough education information about the procedure. Now we've modified it into what we consider a much safer version of the DS, and it has a very powerful hormone response that's really strong for patients with diabetes, and at higher weights, to really optimize weight loss across the board. In this case, we do a gastric sleeve as the first stage and then we bypass the last part of the intestine, again causing some fa, and sugars to not absorb as well. The key to all of these surgeries is that they are all metabolic surgeries with the exception of the band. What that means is they all cause a hormone response that feeds back to our brain, and that's really what causes the

results here. It's not how big you're making the stomach or how small, but it's really how strong of a response in these hormones do we have that helps us feel fullness and change the way we digest and absorb some of our nutrients.

Monica E. Peek, MD, MPH, MSc:

Great. That's excellent information to know. We know so much more about the hormonal status and the connections between our brain and the signaling than we knew when I went to medical school, which I always tell my kids was in 1932. I like the idea of calling it a metabolic surgery because it helps patients, and society really understands that this is a metabolic disease, not just one of willpower. So, Dr. Salles, can you tell us about some of the guidelines about when primary care physicians should think about referring patients for bariatric surgery, because I know the guidelines have changed over time, and what the guidelines tell us?

Arghavan Salles, MD, PhD:

Yes, absolutely. As you're alluding to for a long time, we were going off of a National Institutes of Health (NIH) consensus statement from the early 1990s. Folks who work in this field, bariatric metabolic surgeons, were for a long time saying, "This is wild. We really need to update. Our society has changed so much, and the rates of obesity have changed so much, and our understanding of how to treat obesity has changed so much. Why are we still using guidelines from 30 years ago?" A couple of years ago, these new guidelines came out from the American Society for Metabolic and Bariatric Surgery (ASMBS) and the International Federation for the Surgery of Obesity (IFSO) to really modernize the indications for metabolic and bariatric surgery. For adults, the indications are now for a patient who has a body mass index (BMI) of 30 or greater with other medical problems such as diabetes or high blood pressure, or other things that may be related to metabolic issues.

For patients who have a BMI greater than 35 who don't have any other medical problems, just that level of obesity itself will be qualifying for bariatric surgery, among, well, I should just say there's also a growing interest in and a need for adolescent bariatric surgery. For adolescents, the guidelines are for patients who have a BMI that is either greater than 35 or greater than 120% of the 95th percentile for their age who also have associated medical problems, or a BMI greater than 40, or a BMI with that is greater than 140% of the 95th percentile for their age. Also, when I was practicing clinically, there would often be patients who are in relatively good health, aside from obesity, and maybe a couple other medical problems who are older. And the question would always come, Is there a benefit for those patients?

I think there's a growing recognition that there really can be. It's very customized to the patient and looking at their individual risks and benefits, but there is not a specific cutoff beyond which we don't offer bariatric surgery to patients at this point. In addition, there are some other special situations in which bariatric surgery may be considered for patients, in particular patients who need some other special surgeries but don't qualify for them just yet because of their obesity. Those are patients, for example, who may need a joint replacement, an abdominal hernia repair, or organ transplantation. So, bariatric surgery can help patients lose weight and become healthier in the interim so that they can qualify for these other procedures that they need to have. In general, as Dr. Husain said, the key procedures that are most commonly offered in the United States at this point are the gastric bypass and the sleeve gastrectomy.

Monica E. Peek, MD, MPH, MSc:

One of the things I want to just add is that for me, as a primary care physician, I remember years ago, very few of my patients would be eligible with insurance coverage for this procedure. Now, almost all of my patients, or many of my patients, have a BMI that's greater than 30, which is the lowest point for the consideration of obesity. Many of my patients have diabetes, hypertension, some comorbidity. That means that almost that many of your patients are going to qualify or meet the guidelines. It is not the same sort of high step for thinking about who might be a candidate. As we're now in a phase where almost everyone is trying to be on a GLP-1 receptor agonist, and thinking about the long-term expensive medications, the overall cost of having a surgery may be, in the short term or in the long term, more cost effective.

Arghavan Salles, MD, PhD:

I think that's a great point. Certainly, we're seeing different trade-offs now than say even 5, 10 years ago in terms of weight loss and treatment of obesity. These are, again, going to be individualized decisions in terms of what the patient's goals are both personally and for their health. Also, going through surgery obviously is not a minor ordeal for folks. It's a big deal, especially these surgeries, even though as Dr. Husain was saying that for the surgeon they're technically not too onerous. We can do these, some of them, within as short as a half hour, some of them a couple of hours, but they're relatively straightforward for us on the technical side, and patients are only in the hospital briefly. So, in that sense, it might seem like it's not as big a deal as a Whipple, a pancreatic cancer surgery, but it's still a really big deal for a patient, and their lives, and having to take time off work, and having someone help them and support them because these changes, although they're made through these little tiny holes, they're pretty major on the inside. So, patients do need a fair amount of support afterwards.

So, these are important conversations for patients to have both with their primary care providers and then also if they do get a referral for surgery to talk with their surgical team about whether it really is the right thing for them. I do want to highlight something that Dr. Peek brought up, which is that more patients certainly are eligible for bariatric surgery now, but even before these expanded guidelines, a very small proportion of patients who were eligible for bariatric surgery were getting referred for surgery. There are a lot of reasons I'm sure for that, including the things we were just talking about, that surgery is not a minor thing, and so people may be hesitant to recommend that for their patients. At the same time, we do have and continue to have a growing obesity epidemic.

It's helpful I think to start thinking perhaps a little bit earlier on in a patient's journey about whether surgery might be what's going to most help them. I think to this point of who's eligible and who's getting referred, we do see disparities in that, which I'm going to talk about in just a minute, but I want to also address the disparities in outcomes for patients we've seen, with certain minoritized groups seeming to have, on multiple different data sets, worse outcomes after bariatric surgery. This is consistent with any other medical condition that we look at where patients from different backgrounds don't always have the same outcomes in particular. For example, you might think about maternal mortality, and we know that Black pregnant people are two to three times more likely to die related to pregnancy or due to pregnancy-related causes than are White pregnant patients.

It's the same type of issues that we see throughout our healthcare system, which are obviously multifactorial and complex. We know that there are some, what we call social determinants of health, but also I would add bias on parts of various members of the healthcare teams, and also outright discrimination. As much as we'd like

to think that doesn't happen, we know from data that it does. It is a part of the human experience, unfortunately. And there are roadblocks for some patients to access bariatric surgery, whether it's due to insurance and just access to health care overall, or whether we, as physicians, or other health care workers to think of bariatric surgery as a referral for all patients equally or equitably. Even when patients do have access to bariatric surgery or metabolic surgery, different populations, as I was saying, may have worse post-operative outcomes and persistent disparities such as even in our society, structural racism, environmental racism, food deserts that don't affect all our patient populations in the same ways. Those can also contribute to differential outcomes.

For us as bariatric surgeons, I think we really want to think about, How do we make bariatric care more equitable? How do we improve access to bariatric surgery? And how do we optimize outcomes for patients coming from all different backgrounds? To go on to talk a little bit more about access to bariatric surgery, there are multiple studies that have looked at both who gets referred and then also the outcomes of patients. The key points are, as I was mentioning earlier, that we see the same types of patterns as we see for other health problems. Some specific data we can discuss here are, for example, from a study that looked at referrals, a single-center study looking at who among their patients met criteria for bariatric surgery were getting referred. In that study they found Hispanic patients in particular, this was a study in Virginia, were less likely to get referred for bariatric surgery.

You see the rates here. About 2% of Hispanic patients were referred versus 5% for Black and White patients. In that particular study, when they tried to understand why that might be the case, and again, their single-center experience, those patients who self-identified as Hispanic in their dataset were more likely to be self-paid, meaning not have health insurance. That could be a part of why they were not being referred, because of course surgery is relatively expensive. It's hard to know to what extent that particular finding may generalize. But other data suggest that there are other barriers as well, like this other study that was done looking at referrals to cardiology. What they found was that patients of different races and ethnicities were relatively equally likely to be referred for evaluation by a cardiologist, but Black and Hispanic patients were less likely to undergo testing in particular via stress test.

It's hard to know exactly what is driving that difference. But we see, again, in almost any arena where we look at Black and Hispanic patients and other minoritized patients, they are not necessarily getting the same access to health care, either providers, testing, or procedures. And the last thing I want to say here is that when we look at outcomes, as I've kind of alluded to, we do see differences in outcomes among those who do go on to have bariatric surgery. This study looked at data from what's called the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBS AQIP), which is basically monitoring outcomes for all patients who have bariatric and metabolic surgery at qualified centers. They looked at those data from 2015 to 2021 and compared about 220,000 patients, Black and White patients, and looked at their outcomes, and they matched them. So, they did a case control kind of comparison.

What they found was that across mortality, readmissions, and certain complications, including thromboembolism, Black patients had higher rates of those negative outcomes than did White patients. I think the reason we talk about all these data is we need to be thinking about what contributes to these disparities and, as individual health care workers, individual physicians, nurse practitioners, whatever our role is, how can we incorporate best practices into what we do to do whatever we can on our part to improve these outcomes? And not to say that that's the key lever necessarily, because I think, again, we do have some systemic and

structural issues that we need to be thinking about that our health systems, for example, need to be thinking about and certainly that our society needs to do a better job of addressing.

Monica E. Peek, MD, MPH, MSc:

Thank you. That is always sobering data to look at, but it's always good to have that reflection of what is happening and to understand that it's a reflection not just of individual behaviors but also systemic issues that all come together to make it challenging for our patients. Dr. Husain, maybe you can introduce a patient case. We've had a lot of data. Let's translate that into a real scenario. This case I know was informed by an actual patient experience as we were developing this activity. I'll hand it over to you.

Farah A. Husain, MD, FACS, FASMBS:

Absolutely. The patient we're going to discuss in the next few moments is Angela R, a 47-year-old Latino veteran. She has a body mass index of 44 kg/m^2. Her medical comorbidities include type 2 diabetes, hypertension, sleep apnea, and osteoarthritis of her knee. She lives 90 miles from the nearest Veterans Affairs (VA) medical center, and she functions as a part-time home health aide with no paid leave. She is the primary caregiver for her mother as well, and has transportation challenges. At her initial presentation, she came in and reported worsening knee pain, suboptimal glycemic control with an elevated hemoglobin A1C, fatigue, and difficulty sleeping. She has tried numerous diets already. She also participated in the VA MOVE program and has used VA formulary medications such as naltrexone and liraglutide. She has not found any long-term success with the diet plans, the MOVE program, or with any of the anti-obesity medicines that are available thus far.

Monica E. Peek, MD, MPH, MSc:

Thanks very much for starting us off on this case. Before we continue, I want to get our audience involved. So, according to the VA Affairs and the Department of Defense 2020 guidelines, bariatric surgery should be considered when ongoing weight loss (percentage) and non-surgical interventions reflect which of the following? I want you all to record your answers. A, less than 5% after 6 months of lifestyle modifications and concurrent pharmacotherapy. B, less than 10% after 1 year of GLP-1 receptor antagonist therapy. C, less than 5% after 1 year of pharmacotherapy and lifestyle modifications. D, less than 3% after 3 months with either lifestyle modifications or pharmacotherapy. Or E, I'm not sure. Okay. The answer is going to be A, less than 5% after 6 months of lifestyle modifications and concurrent pharmacotherapy. Now let's stop and talk about what we know so far. The patient's primary care clinician recommends bariatric surgery. What do you all think about that?

Farah A. Husain, MD, FACS, FASMBS:

I think this is probably an easy answer, and I am a bariatric surgeon, so that's my disclaimer, but naturally she absolutely should be referred to what I would say now is a comprehensive obesity treatment center. I think most of our programs are transitioning to a comprehensive obesity treatment center because we really think, again I'm going to stress it probably multiple times, that this is a chronic disease, and we want to think of it like we do hypertension or diabetes, but there are layers of treatment that may be needed in each individual to get to their physiologic response. While she has tried lifestyle modifications, she has tried medications, I want people to take failure out of their vocabulary in those terms and instead talk about non-responders, super responders, and low responders.

She has not had a great response thus far to the MOVE program, which is heavily healthy lifestyle modification, the initial anti-obesity medication treatment, she hasn't been on the most optimal medication treatment likely yet. It's absolutely well worth trying that in this patient. And concurrently while you're doing that, it is also absolutely worthwhile getting ready for a discussion about whether surgery is a possibility in the future. I will say that talking about things at the same time and moving forward in multiple lanes is completely appropriate with obesity treatment.

Monica E. Peek, MD, MPH, MSc:

Great.

Arghavan Salles, MD, PhD:

If I could just add one thing, I agree obviously with everything Dr. Husain said and I just want to remind folks in case they're not aware that only 5% of people are able to be successful in terms of long-term weight loss with just diet and exercise alone. So, when people say things like, "Oh, this patient tried diet and exercise and then lost weight and then regained it," as though that's kind of some kind of judgment or a failure on the part of that patient, that's really a very typical experience. It suggests that we as clinicians have not really figured out how to help these patients achieve their long-term goals. This is where optimizing medications certainly can help. It's amazing that we have these GLP-1s now that do seem to help quite a lot of patients. And even for those patients where those medications are really effective, the amount of weight loss is still less than what most patients would get on average with bariatric surgery. Of course, it's hard to know for an individual patient what their outcomes would be, but those are some additional things that I think about.

Monica E. Peek, MD, MPH, MSc:

Very nice. Thank you. Okay, so Dr. Husain, if you can pick up where we left off with our patient case.

Farah A. Husain, MD, FACS, FASMBS:

Absolutely. So, Angela's primary care practitioner does recommend her for bariatric surgery, and she comes to the initial bariatric surgery group information session. While there, she notices she's the only woman of color present. She perceives some judgmental language that is directed at her by the surgeon during this presentation. She hears quotes like "Surgery is not for people looking for an easy way out. You have to prove you're serious." The process requires about a 6-month supervised program before surgery. Angela is naturally worried she has to be able to get time off from work during this time, and has to be able to travel to these multiple appointments.

So, there are many barriers of care in her case. The long travel distance for the pre- and post-op visits is significant because we know she lives over 90 miles away from her closest VA. There's financial strain from costs for gas, unpaid leave, and being away from her caregiving duties for her mom as well. There's some cultural disconnect in communication and how she's hearing that message that's being sent by the surgeons. I think that, as surgeons, something we really need to own is that sometimes we think the things we're saying are encouraging people. “It's not the easy way out.” “You have to work hard.” But it can be perceived as very negative for the patients. So, understand that and really think about how we're communicating this message of commitment to this process without it being a punitive-type thing being put on them.

There are a lot of rigid eligibility requirements currently with insurance, and this is my soapbox likely that sometimes insurance determines our care. There are many steps that may or may not be medically necessary but are predetermined as mandatory by insurances. That can make it very hard for people to complete the pathway. And there's implicit bias in this presentation, focusing on motivation instead of systemic barriers and physiologic knowledge of obesity as a disease, again not quite recognizing that it's not about your self-control or your motivation but that your brain determines a lot of times what your weight and your body habitus is and how you respond to treatment. Are we supposed to strong-will ourselves out of our brain's functioning? That's the question, and the answer should be no, that we need to reword that in our own world as well.

Monica E. Peek, MD, MPH, MSc:

All of those are such excellent points, because even though the guidelines have changed about eligibility, there are still so many structural issues that make it difficult for people to still access the same care. And then you mentioned a lot of the cultural disconnects when people of color are frequently already stereotyped as being lazy, unmotivated, or non-adherent, and those messages may trigger other experiences they've had or feelings they've had about care. So, all of these things are really important for us to notice that this may be baggage people are bringing with them to the encounter that may make their experience less than ideal. So, we should think about social drivers of health, social determinants of health, and how they relate to bariatric surgery, and Dr. Salles already did a really good job of describing so much of that when she was talking about disparities in care around insurance, the structural inequities around race and ethnicity, and how that is related to class and income.

It's also related to education, health literacy, and your job in this country, which determines for the most part your insurance level still. Many of these things really are driven by poverty and your access to resources. Some is related to geography and whether or not you're in a rural versus an urban area. Many times rural areas just don't have the physical resources. And then if you're in a very urban area that's low income, you may still be in a desert despite the urban area having a lot of resources. You may still be on the south side of Chicago or on the west side of Philadelphia where there must still be a lot of resources that you're missing. And while there are structural inequities in our society, those same structural inequities exist within our healthcare system. All of these things are on patients as they navigate our healthcare system, as they navigate life outside of our healthcare system to make them susceptible to obesogenic environments, and effect whether or not they're even candidates for surgery and their ability to access surgery. These are things that are really important.

This next slide shows some sample questions that we may want to ask in terms of bariatric surgery that we could ask our patients to try to get to some of these social drivers, and then be able to try to address them to try to decrease the barriers that patients have and be more patient-centered in increasing the access of everyone to equal care. So, instead of assuming that people's non-adherence is related to a lack of willingness to take medications, I'm always ask them what happened. I was in clinic all day yesterday, and someone was like, "Well, I'm taking all these medications, but it's the last refill," and I looked and it was true that they were only given a 30-day medication with zero refills. So, I said, "I'm going to put in for 90 days with three refills. You shouldn't have to be constantly asking through the phone tree to get medication refills and stuff." There are a lot of things that we can do as providers within our systemic limitations to try to make things easier for patients.

Arghavan Salles, MD, PhD:

I think if I could just add to that, I 100% agree with all of that. I think we have a tendency, especially when we are very busy and struggling to just keep up with our own work and seeing all the patients we need to see, it can be easy to excuse things like, "Well, this patient's not doing well because they have poor health literacy, because they have poor education, because they didn't do XYZ thing." I think one really big challenge for us in health care is to shift that thinking along the lines of that slide and recognize the limitations that our patients have through no fault of their own, and what can we be doing better to help patients who don't have access to resources to achieve the same health outcomes as other people who do? Of course that's going to take investment from our healthcare systems. That's not a thing that we're going to one by one try to solve ourselves, and we have to put pressure on our healthcare systems to do better by our patients.

Monica E. Peek, MD, MPH, MSc:

Exactly. Recognizing that we're in a system that's full of structural inequities, how can we think about those and try to balance some of that out for our patients who are trying to navigate their way to wellness? So, next we're going to shift to talking about some of the interpersonal issues and implicit bias. This one statement that we've talked about already about from a surgeon is really revealing, where the surgeon said, "Surgery is not for people who are looking for an easy way out. You have to prove you're serious." Implicit bias. This is a definition. It's an automatic reaction that we have towards people. These attitudes and stereotypes can negatively impact our understanding actions and decision-making about people. Biases are cognitive shortcuts. They help us make sense of the world to categorize things, people, and places quickly to help us digest large volumes of information. They're evolutionary, something that helps us process large data. That's great, but sometimes they fire in ways that are not helpful and create negative things for us and for other people. So, we have to use our slow cognitive pathways to help us put into check these negative shortcuts to help us make sure that we are practicing the best care we can for patients, and we can actually measure our own biases with a number of tests. There's one called the Project Implicit website that was developed, and we can sort of measure our implicit biases for a number of different things, but it's really important that we all acknowledge that we have them, that they impact patient care, and so then we can begin to do something about it. We have biases not just by race and gender but also by weight. Dr. Salles, can you talk about the statement obesity bias is the last socially acceptable form of prejudice? What does that mean?

Arghavan Salles, MD, PhD:

I'll admit that that's a little bit dated now. I mean, this is something that we used to say maybe about 5-ish years ago, and I think it was relatively true at that point in time that we had become, as a society, more aware of how certain statements might be inappropriate with regard to, for example, a person's sex or a person's race or ethnicity. Yet people would pretty consistently and freely make negative judgments about people with obesity without really seeming to expect any backlash around that. And that's kind of what that statement was about, that obesity bias is so omnipresent that it didn't really seem to raise a red flag for people in the same way that other types of stereotypical statements or discriminatory statements about other aspects of identity might. I have to say, I do feel a little bit that that may no longer be the case as we have turned a tide in a sense in our society, where we're seeing more rather than less discriminatory statements being made by our so-called leaders, by the media, and just by people in our everyday lives.

So, I'm actually not sure that that statement is accurate anymore, although I do think for sure that people still feel very comfortable making negative judgments of people with obesity in ways that they should not. The data that we have on this are plenty. There have been many, many studies showing that people in the general public hold negative views about people with obesity, but also so do physicians and other health care workers. Some of the data that's out there are looking at, for example, physician associates and psychology students who tended to say that patients with obesity are difficult, unmotivated, and noncompliant. Those were the terms used in that study. Many of them had also witnessed negative comments about people with obesity from others during the course of their training. There are older data from the Implicit Association Test (IAT) that, as you just mentioned, from Project Implicit, showing that physicians hold moderately or strong negative implicit bias about patients regardless of their own weight.

Sometimes people ask if people with obesity have less negative bias about people with obesity, and it tends to generally not be the case. I mean, implicit bias tends to be a reflection of the society we're in more than individual's beliefs or anything like that. It's the same reason you see women will also hold negative implicit biases about women and careers, for example. We published data on that if anyone's interested. But anyway, let's continue on with what we know about obesity and people's perspectives. There are studies, even large studies, showing that, again, medical doctors, regardless of their BMI, race, ethnicity, or gender, hold anti-fat bias. And I'll just make a small note there that the IAT that is done for obesity uses the term "fat" as opposed to using the term "obesity" that may be more stigmatizing. There hasn't been a direct comparison of using one term or the other for the IAT, but just a little footnote there. And there are other data that show that providers tend to view patients with obesity as non-compliant, lazy, lacking self-control, awkward, weak-willed, sloppy, unsuccessful, unintelligent, and even dishonest. So, these views are, again, pretty prevalent even in the medical environment. And that of course, I hope it's obvious to folks, can lead to worse outcomes for patients with obesity and, in my opinion, likely contributes to some of the disparities we see in health outcomes for patients with obesity.

So, there are some little things that we can do in our clinics to try to be a little bit less stigmatizing for people with obesity and to make them feel more comfortable and welcome in our spaces. That's things like not having arms on our chairs or having much wider chairs than some clinics typically do, just to, again, indicate that we understand people of all different sizes may come into our clinic. It also includes things like having blood pressure cuffs of different sizes to fit different people and making sure that our exam tables can support different weights and that our gowns also come in different sizes, so that pretty much everyone who comes into our clinic spaces can feel comfortable. The last thing anyone wants is to feel like the space is not made for them.

Monica E. Peek, MD, MPH, MSc:

Right. I noticed that when we made a change in our chairs so that we had double-sized chairs in our rooms. I noticed it and I think that our patients probably noticed that as well, and it made a big difference. So, we have one more audience response question. The question is, Which of the following is considered a non-stigmatizing term with respect to individuals with obesity and related comorbidities? A, weight loss surgery. B, morbidly obese. C, uncontrolled diabetes. D, bariatric-metabolic surgery. Or E, I'm not sure. So, the answer is bariatric-metabolic surgery. I'll let you all quickly weigh in on some of the reasons why that might be. But just for me, just jumping out, there's "uncontrolled" with "diabetes," "morbid" with "obese," and then with the surgery sort of

focusing on the weight loss aspect of it as opposed to the surgery, just describing what it is without any sort of judgment or subjective assessment of that. Anything else that you guys would want to add to that?

Arghavan Salles, MD, PhD:

Yes, just very quickly, I would add that there was a great article that came out a few years back that looked at the language that we use around obesity and how it can be stigmatizing, just kind of underlying the point that was made by that question, that there are some very simple things we can do to shift our language. For example, instead of saying “obese,” we can talk about “obesity” and use person-first language. So, “This is a person with obesity,” not “an obese person.” Instead of, just as you were saying, talking about “morbid obesity," we can talk about “severe obesity.” Instead of talking about things that are good or bad, we can talk about things that are more or less healthy in terms of, for example, food or habits that people might have.

Instead of talking about “exercise,” we can talk about “physical activity,” which seems to be less off-putting to a lot of people. You've already heard probably in this session that instead of using “non-compliance,” we're tending to use “non-adherence.” Then in terms of any sort of endeavor around weight loss, whether it's medications or surgery, people sometimes will talk about “recidivism,” which is a term that's really associated with crime and doesn't really fit in the healthcare setting. So, we should talk about “weight regain,” not “recidivism.”

Monica E. Peek, MD, MPH, MSc:

Absolutely.

Arghavan Salles, MD, PhD:

In addition to some of the data we discussed earlier around the IAT, our team did just recently publish an update looking at more recent data to see if there were any changes in the opinions or perspectives for both implicit and explicit bias among folks who care for patients. The real key takeaways I want to briefly summarize are that folks, which the IAT categorizes as diagnosing and treating practitioners such as physicians and dentists and folks who are making treatment decisions, tended to have higher levels of anti-fat bias than other types of health care workers or people who are not health care workers. However, the good news is that across all the groups of folks included in these data, which was by the way over a million folks represented, about 40,000 of them being health care workers or diagnosing and treating practitioners, I should say, across all three of these groups, there tended to be less explicit bias over time, which I think is a positive finding.

Explicit bias is what we say we believe, whereas implicit bias is more automatic and unconscious. So, it could be that we see this because there is a greater recognition that it's not appropriate to have bias against people with obesity, or it could be that attitudes are really changing. Unfortunately, those data don't allow us to disentangle that.

Monica E. Peek, MD, MPH, MSc:

All right, thank you, Dr. Husain. We're going to go back to our patient case and see how it wrapped up and how it concluded.

Farah A. Husain, MD, FACS, FASMBS:

Great. Well, Angela did decide to proceed with surgery and elected to have a gastric bypass. After gastric bypass, she was readmitted for dehydration due to unclear discharge instructions. She misses follow-up because of transportation issues and lack of flexible scheduling. One year later, she's regained 30 pounds, and her diabetes has returned to pre-op levels. So, the key takeaways here are that bariatric surgery outcomes are influenced by not only patient behavior but by systemic cultural and structural barriers that clinicians must actively identify and address. Many of these barriers were really clearly identified in a preoperative assessment but then not addressed adequately in the perioperative care, leading to some of these challenges that she faced.

Monica E. Peek, MD, MPH, MSc:

I think that's a wonderful way of phrasing that we saw them in the pre-op as “flags,” things that she was concerned about, things that we were thinking about that then manifested. And then Dr. Salles had talked about some of the post-op disparities that we see. A lot of this could be avoided if we had a more coordinated team, if we had some case management and care management. So, how do you all work as part of interprofessional teams in bariatric care, and what does that look like in your practices?

Farah A. Husain, MD, FACS, FASMBS:

Right now, I think of our practices as being quite lucky in our team approach and our interprofessional care. One of the advantages we have, I think over sometimes primary care, that can be very resource lacking is that part of having a certified bariatric team is having the inclusion of people like registered dieticians and behavioral health therapist, in the form of anything from psychologists to social workers, psychiatrists, et cetera, and having nurse navigators who can help patients with some of the challenges that they're facing. So, we have this interdisciplinary multidisciplinary team, and what it really helps with in my impression is that it's not on one person to catch all of these things.

Regarding those questions we talked about, how do you incorporate those questions to identify some of the challenges that patients may face? In our practice, often they're part of our normal workflow now because our dieticians do such a wonderful job of identifying barriers. They talk about “How do you prep your food generally?” and “Where do you eat?” and “Where is the closest grocery store to you?” et cetera. They're bringing that to us, and it's really helping to share the load of caring for the patient the best way we can.

Monica E. Peek, MD, MPH, MSc:

Yes, yes. Thank you. Okay, ladies, we are out of time, but I thank you so much for this session. It’s been very, very informative, and I appreciate your personal dedication and service for this patient population, for all the work that you do. Thank you for joining us today. I'm going to try to summarize with a few brief SMART goals, and those are goals that are specific, measurable, attainable, relevant, and timely. Our SMART goals for today are to recognize obesity as a disease and to treat all individuals, particularly of differing racial and ethnic backgrounds and different kinds of social identities, with dignity, regardless of body size. Our second is to encourage empathy and understanding by all team members and to reflect on your own potential implicit biases. Our third is to refer and/or treat patients with severe obesity who are appropriate candidates and interested in bariatric surgery. And our last SMART goal is to focus on health and function improvements and avoid framing weight solely as a personal responsibility. Really, this is a chronic disease. It's a pathophysiologic

condition with a lot of hormonal imbalances, and we need to be thinking about this like we would any other chronic condition.

There are a lot of suggested resources that are here for you as you help your patients navigate their way to wellness as we have for all of our chronic conditions. So, these are here for you. Thank you all for joining us. Please don't miss the other program in this series, which is entitled *Advancing Health Equity Across the Spectrum: Optimizing Biomarker Usage in Non-Small Cell Lung Cancer*. We also encourage you to visit our CME Outfitters Health Access and Social Responsibility Hub at the URL that's on your screen. To receive credit for this activity, please complete the post-test and evaluation, then you'll immediately receive your certificate for your participation today. Thank you again to our audience for joining us today, and thank you to our guests so much for your expertise, your time, and all that you do. Thanks so much.