American Association of Clinical Endocrinology (AACE) Consensus Statement

Addressing Stigma and Bias in the Diagnosis & Management of Patients with Obesity/Adiposity-Based Chronic Disease (ABCD)

AACE2023

Background

Consensus Conference

May, 2022 San Diego

Interdisciplinary Healthcare Professionals

- The interplay between the diagnosis of obesity using ABCD nomenclature and:
  - Staging
  - Weight Stigma
  - Internalized Weight Bias (IWB)
- Development of actionable guidance to aid clinicians in mitigating IWB & stigma in that context

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Thank you to our participating organizations!

Academy of Nutrition and Dietetics

American Academy of Family Physicians

American Association of Nurse Practitioners

American College of Sports Medicine

American Diabetes Association

American Heart Association

American Osteopathic Association

American Society for Metabolic and Bariatric Surgery

American Society for Nutrition

Endocrine Society

European Association for the Study of Obesity

International Society of Sports Nutrition

Obesity Action Coalition

Obesity Canada

Obesity Medicine Association

The Obesity Society

Consensus Conference Agenda

Presentations

- Background, Goals, and Objectives for Obesity Consensus Statements
  Dr. Karl Nadolsky
- International Dialogue on Weight Bias and Cultural Issues
  Dr. Ximena Ramos Salas
- Clinical Importance of Obesity Stigma and Internalized Weight Bias-Health Care Perspective, Including Racial and Ethnic Disparities in Obesity
  Dr. Monica Agarwal
- Patient Perspectives on Stigma and Internalized Weight Bias
  Mr. Ted Kyle and Ms. Nikki Massie
- Summary and panel discussion

Results of Survey & Conceptualize Biopsychosocial Model of Obesity

- Attendee question and answer

Breakout Discussions

- Perception and diagnosis of obesity
- Obesity stigmatization/weight bias and mental health
- Report to group

Concluding remarks and preparation for consensus statement

2014 AACE/ACE Obesity Consensus Conference

"**Affirmed concepts**" (ACs) representing the validation of previously held concepts and practices

"**Emergent concepts**" (ECs) that became apparent only through the vigorous analyses and discussions emanating from the multidisciplinary cohort of attendees

EC # 1: medically meaningful & actionable diagnosis of obesity

- Advanced Framework
  - Anthropometric & clinical descriptors
  - Diagnosis & Management requires screening via anthropometrics and complications, staging severity of obesity based upon complications and algorithmic management in complication-centric manner

Garvey, et al. Endocr Pract. 2014 Sep;20(9):977-89

Gaps and Barriers to Care - for the Obesity Consensus Statement

Many clinicians are not aware of barriers and how to address them, to improve the effective management of obesity in clinical practice.

- Obesity-related bias and stigma is pervasive
- Associated with both mental and physical consequences
- Causes discriminatory problems in employment, education, the healthcare setting, and society in general

More clinicians need to develop effective obesity treatment plans.

Clinicians are faced with a significant number of challenges in clinical care about the management of obesity, including:

- Ineffective strategies for communicating with patients
- Unfamiliarity, or lack of confidence with treatment modalities such as pharmacologic or surgical intervention
- Lack of understanding about the importance of formal prescription for diet and exercise
- Lack of time
- Unfamiliarity with guidelines and established effective treatment options

Joint International Consensus for Ending Stigma of Obesity

MultiD International Experts

Reviewed evidence on causes & harms of weight stigma

- People with obesity commonly face social stigma
  - Pervasive & resilient
- Discrimination
  - Workplace
  - Education
  - Healthcare
- Physical & Psychological harm
  - Less likely to receive adequate care
- Developed recommendations to eliminate weight bias

Box 1. Key Definitions[a]

- **Weight bias** = negative ideologies associated with excess body weight
- **Weight stigma** = thoughts and acts of discrimination towards individuals due to the weight and size and a result of weight bias
- **Internalized weight bias** = when a person applies negative weight stereotypes (bias) to themselves and engage in self devaluation
- **Implicit weight bias** = unconscious bias toward a person who has obesity, beliefs or attitudes outside of an individual's awareness and control
- **Explicit weight bias** = awareness of bias and intentionally behaving negatively towards a person who has obesity

Rubino F, et al. Nat Med. 2020;26(4):485-497

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Definitions

Weight Stigma refers to social devaluation and denigration of individuals because of their excess body weight and can lead to negative attitudes, stereotypes, prejudice, and discrimination.

Weight-based stereotypes include generalizations that individuals with overweight or obesity are lazy, gluttonous, lacking in willpower and self-discipline, incompetent, unmotivated to improve their health, non-compliant with medical treatment and are personally to blame for their higher body weight.

Weight discrimination refers to overt forms of weight-based prejudice and unfair treatment (biased behaviors) toward individuals with overweight or obesity.

Weight bias internalization occurs when individuals engage in self-blame and self-directed weight stigma because of their weight. Internalization includes agreement with stereotypes and application of those stereotypes to oneself and self-devaluation.

Explicit weight bias refers to overt, consciously held negative attitudes that can be measured by self-report.

Implicit weight bias consists of automatic, negative attributions and stereotypes existing outside of conscious awareness.

Rubino, et al. Nat Med. 2020;26(4):485-497

Joint International Consensus Statement for Ending Stigma of Obesity

Table 2 | Consensus statements on the stigma of obesity

Item	Topic	Grade
1. Prevalence of weight stigma and weight-based discrimination		
1.1	A substantial body of evidence demonstrates that weight-based stigma is extremely pervasive among people of diverse ages and backgrounds.	A
3. Weight stigma in healthcare		
3.1	Many healthcare professionals hold negative attitudes about obesity, including stereotypes that affected patients are lazy, lack self-control and willpower, are personally to blame for their weight, and are noncompliant with treatment.	A
3.2	Weight-based stigma among healthcare professional is unacceptable, especially among those who are specialized in the care of people with obesity.	A
5. Physical and mental health consequences		
5.1	Weight-based stigma and internalized weight bias can be particularly harmful to mental health, increasing risks of depressive symptoms, anxiety, and promoting lower self-esteem, social isolation, stress, and substance use.	U
5.2	Adults and children who experience weight-based stigma are more likely to avoid exercise and physical activity, and to engage in unhealthy diets and sedentary behaviors that increase the risk of worsening obesity.	A
6 Quality of care, access to care		
6.1.	Quality of health care is adversely affected by weight-based stigma.	U
6.2	Fear of prejudice and internalized weight bias cause direct and indirect harm to patients with obesity, as they are less likely to seek and receive appropriate treatment for obesity or other conditions.	A
6.3.	Despite the well-recognized risks of obesity and related illnesses, it is common for health insurance companies to have significant limitations or complete lack of coverage for evidence-based treatments of obesity—especially metabolic surgery. These policies can cause harm, are indefensible, and are ethically objectionable.	A

Rubino, et al. Nat Med. 2020;26(4):485-497

Joint International Consensus Statement for Ending Stigma of Obesity

Table 2 | Consensus statements on the stigma of obesity

Item	Topic	Grade
9. Causes and contributors of weight stigma/discrimination		
9.1	Causal attributions of personal responsibility for obesity are associated with stronger weight bias whereas lower levels of weight-based stigma are associated with stronger beliefs in genetic/physiological or environmental causes of obesity.	U
9.3	The idea that the causes of obesity depend on individuals' faults, such as laziness and gluttony, provides the foundation for stigma against obesity.	A
10. The science of obesity versus misconceptions in the public narrative of obesity		
10.1	The assumption that body weight is entirely under volitional control, and that voluntarily eating less and/or exercising more can entirely prevent or reverse obesity is at odds with a definitive body of biological and clinical evidence developed over the last several decades.	U
10.3	The idea that obesity is a 'choice' is a misconception, inconsistent with both logic and scientific evidence showing that obesity results primarily from a combination of genetic, epigenetic, and environmental factors.	A
10.4	There is a widespread assumption, including among many medical professionals, that voluntary lifestyle changes (diet and exercise) can entirely reverse obesity over long periods of time, even when severe. This assumption runs	A
11. Obesity: 'condition' or 'disease'?		
11.1	There is objective evidence that in many patients, obesity presents the typical attributions of a disease status, which include specific signs and/or symptoms, distinct pathophysiology, reduced quality of life, and increased risk of complications/mortality.	U

Rubino, et al. Nat Med. 2020;26(4):485-497

Joint International Consensus Statement for Ending Stigma of Obesity

Table 3 | Consensus statements on the stigma of obesity: recommendations

Item	Topic	Grade
2	Explaining the gap between scientific evidence and the conventional narrative of obesity built around unproven assumptions and misconceptions may help reduce weight bias and alleviate its numerous harmful effects.	A
3	The conventional narrative of obesity built around unproven assumptions of personal responsibility, and misconceptions about the causes and remedies of obesity causes harm to individuals and to society. Media, policy makers, educators, HCPs, academic Institutions, public health agencies, and government must ensure that the messages and narrative of obesity are free from stigma and coherent with modern scientific evidence.	A
4	Obesity should be recognized and treated as a chronic disease in healthcare and policy sectors.	A
Media		
5	We call on the media to produce fair, accurate, and non-stigmatizing portrayals of obesity. A commitment from the media is needed to shift the narrative around obesity.	U
Healthcare and education of HCPs		
6	Academic institutions, professional bodies, and regulatory agencies must ensure that formal teaching on the causes, mechanisms, and treatments of obesity are incorporated into standard curricula for medical trainees, and other HCPs.	U

Rubino, et al. Nat Med. 2020;26(4):485-497

Canadian Obesity CPG: Obesity in adults: a clinical practice guideline

KEY POINTS

- Obesity is a prevalent, complex, progressive and relapsing chronic disease, characterized by abnormal or excessive body fat (adiposity), that impairs health.
- People living with obesity face substantial bias and stigma, which contribute to increased morbidity and mortality independent of weight or body mass index.

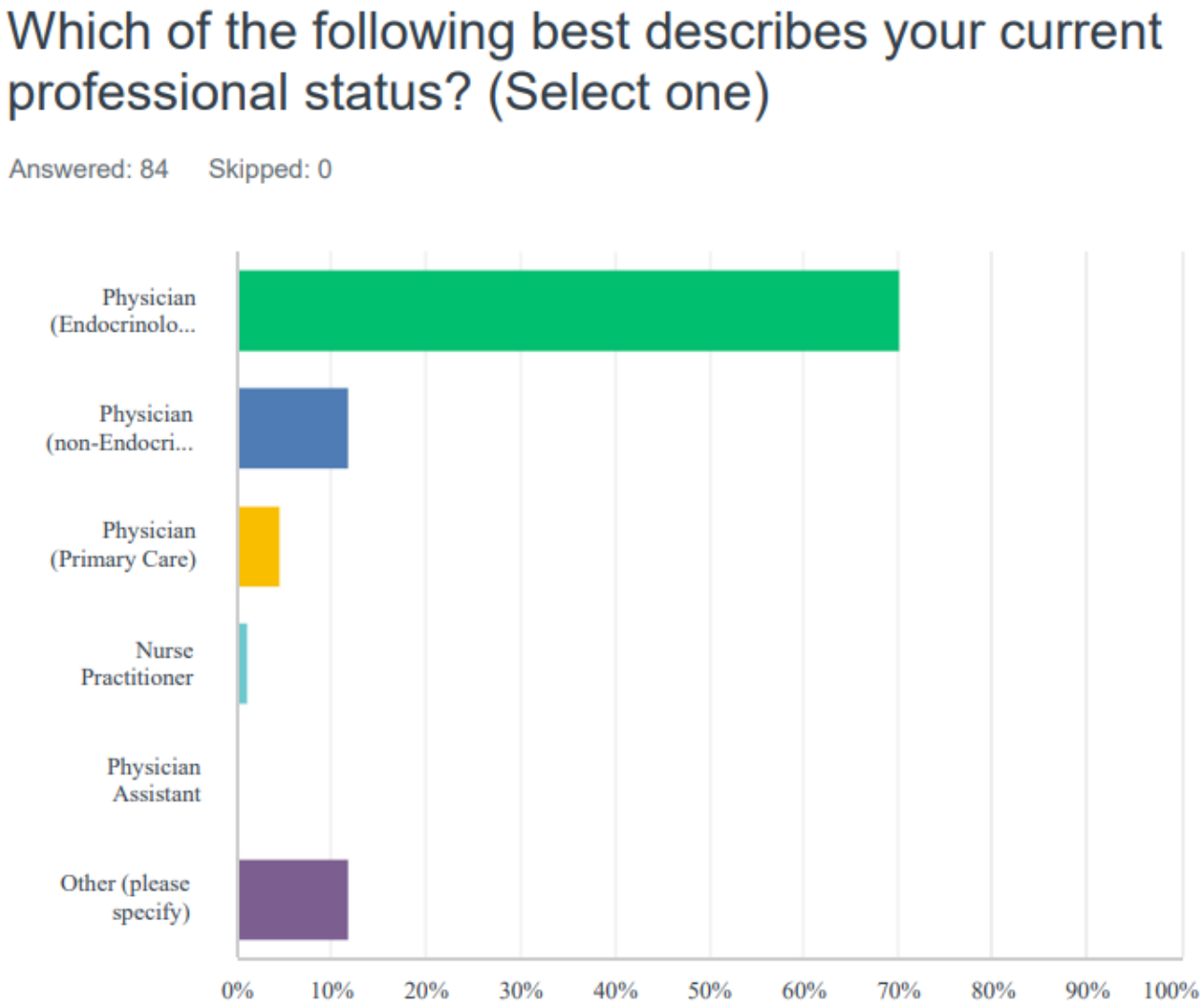
	Recommendations	Category of evidence and strength of recommendation†
Reducing weight bias in obesity management, practice and policy		
1	Health care providers should assess their own attitudes and beliefs regarding obesity and consider how their attitudes and beliefs may influence care delivery.	Level 1a, grade A
2	Health care providers may recognize that internalized weight bias (bias toward oneself) in people living with obesity can affect behavioural and health outcomes.	Level 2a, grade B
3	Health care providers should avoid using judgmental words (level 1a, grade A), images (level 2b, grade B) and practices (level 2a, grade B) when working with patients living with obesity.	See recommendation
4	We recommend that health care providers avoid making assumptions that an ailment or complaint a patient presents with is related to their body weight.	Level 3, grade C

Wharton S, et al. CMAJ 2020;192:E875-91

AACE Obesity Diagnosis and Stigmatization Survey

84 Participants representing several professional societies and patient advocacy

- Pre-conference survey
  - Developed by steering committee
  - Degree of agreement/disagreement
    - Statements related to:
      - Stigma/Bias
      - Nomenclature
      - Staging & Classification
- Goal Consensus 3 Key Areas:
  - Perception & Diagnosis
  - Stigma & Bias Impacts on Mental Health
  - Training gaps/needs for professionals



Obesity is a disease

Obesity is a complex progressive and relapsing disease associated with weight bias and stigma.

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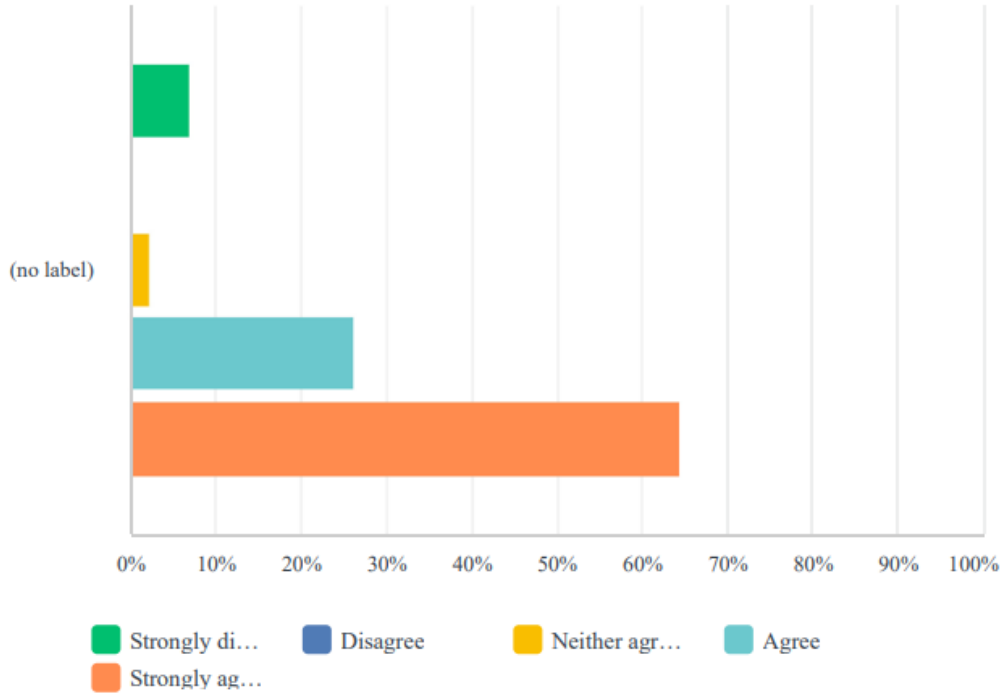

Obesity is not a lifestyle choice but is a serious multifactorial disease requiring advocacy.

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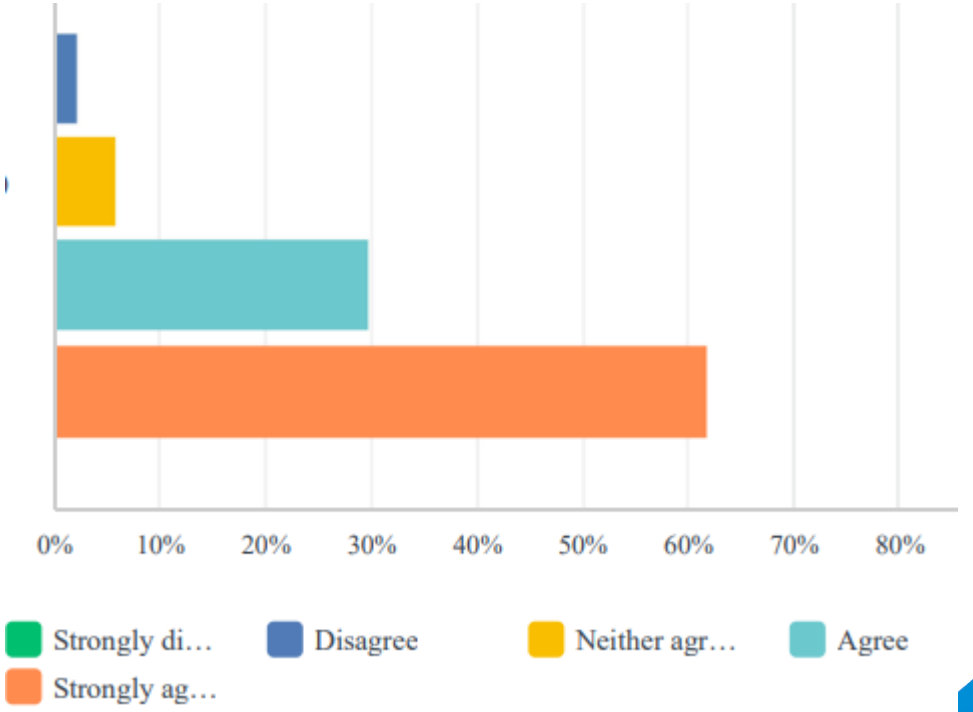

Definition of Obesity

Criteria for a disease

- Impairment of normal functioning
- Characteristic signs or symptoms
- Harm or morbidity

2012: AACE asserted that obesity is a **disease** with multiple pathophysiological aspects, including genetic, environmental, physiological, and psychological factors

Obesity is a chronic relapsing progressive disease defined by *abnormal or excessive* ***adiposity*** that may *impair* ***health***

Mechanick, et al. Endocr Pract 2012;19(5):643-648; Bray GA, et al. Obes Rev. 2017;18(7):715-723; Jastreboff AM, et al. Obesity (Silver Spring) 2019;27:7-9

Does BMI contribute to bias & stigma?

The current BMI-centric diagnostic classification system promotes weight bias and stigma, hindering individualized care pathways for treating obesity.

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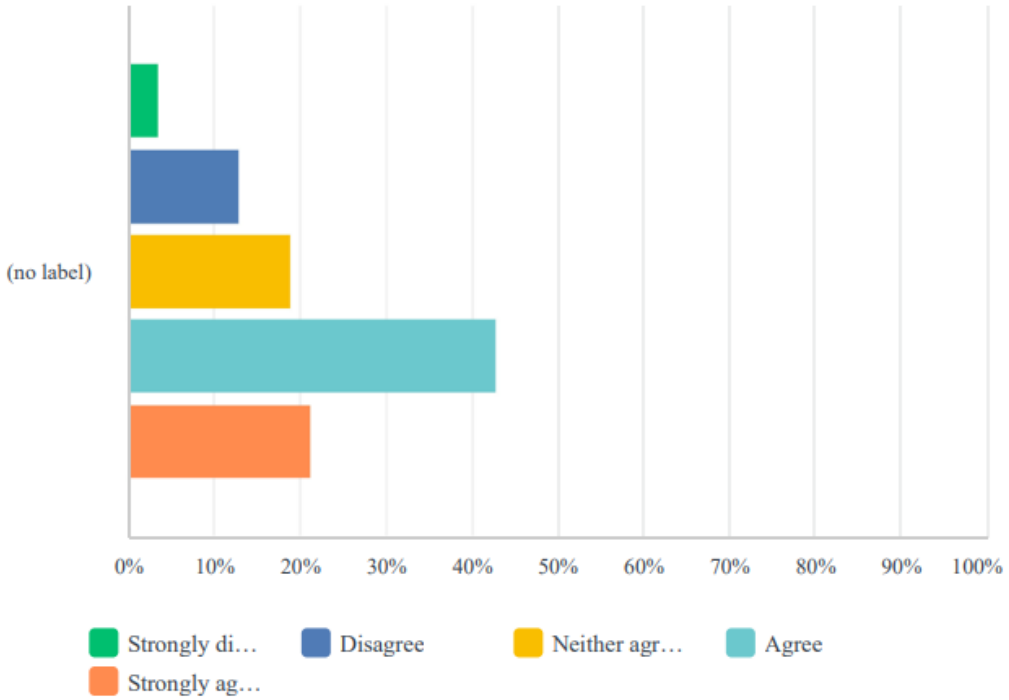

Use of the ABCD (adiposity based chronic disease) paradigm for diagnosis & staging, beyond BMI, individualizes care according to disease severity and complications.

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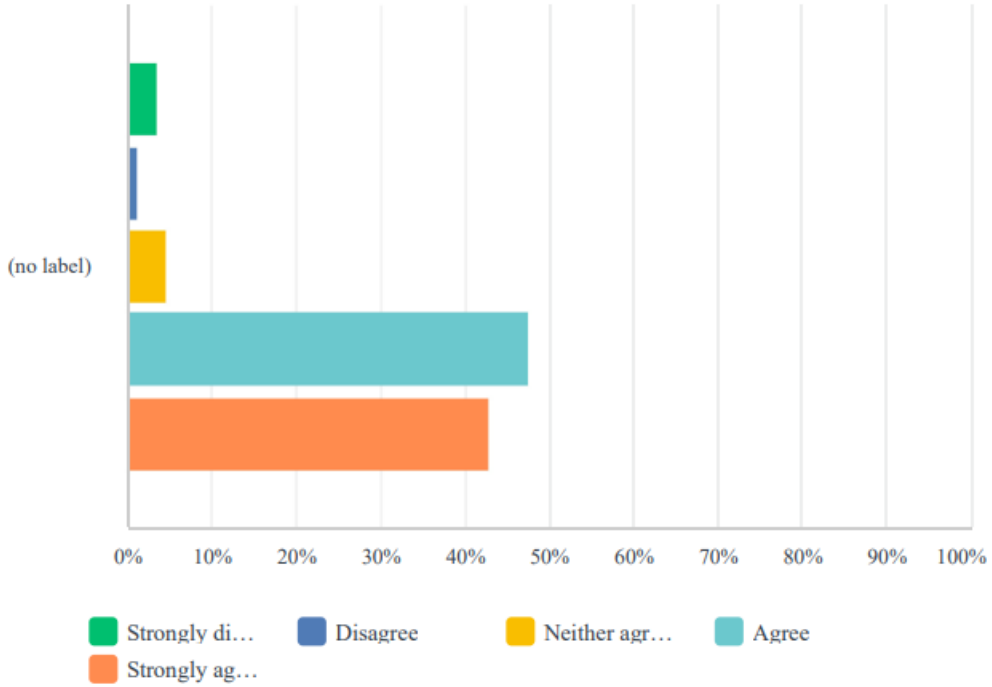
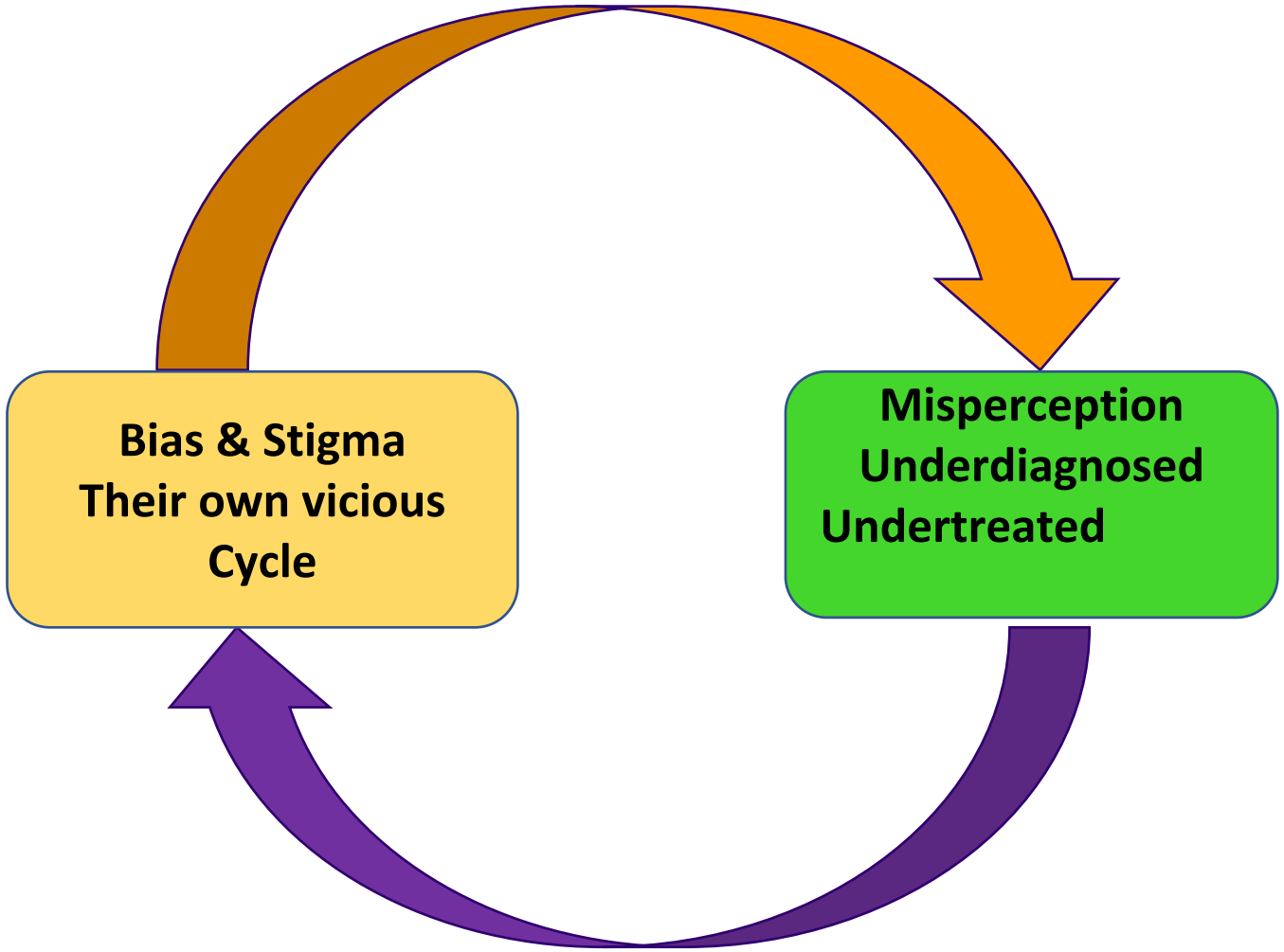
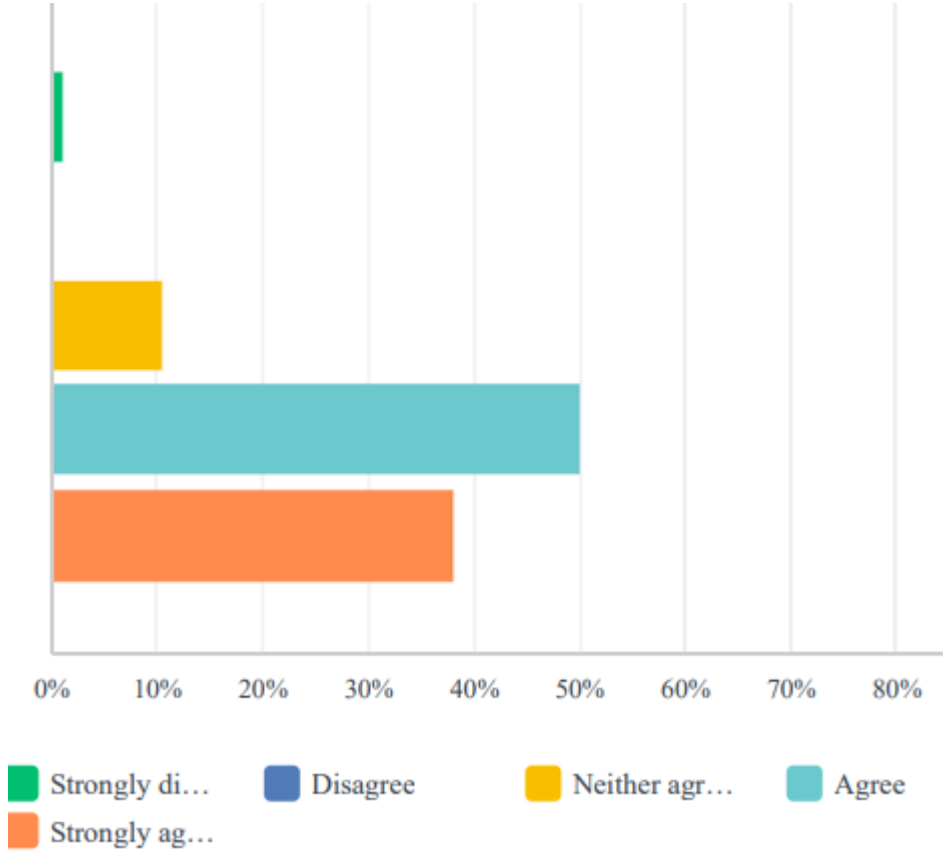


Vicious Cycle of Stigma/Bias & Perception/Diagnosis

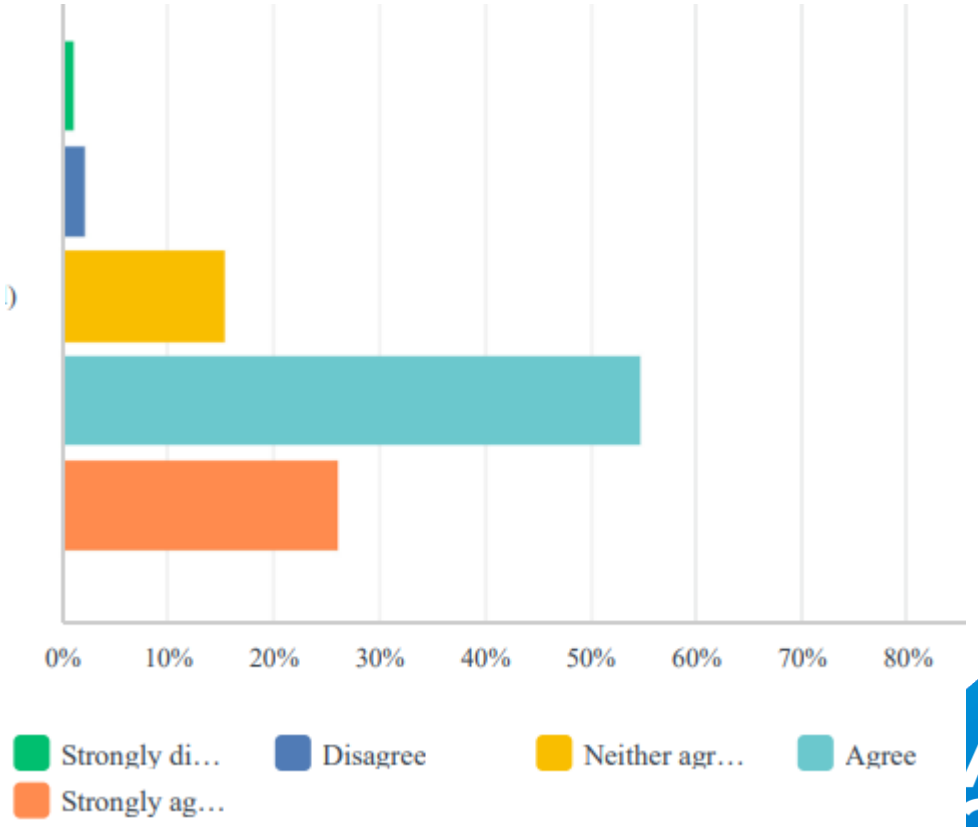


Weight Bias Among Patients & Healthcare Professionals

Sources of weight bias for patients with obesity seeking healthcare include internalized weight bias among patients and implicit and explicit bias among healthcare professionals

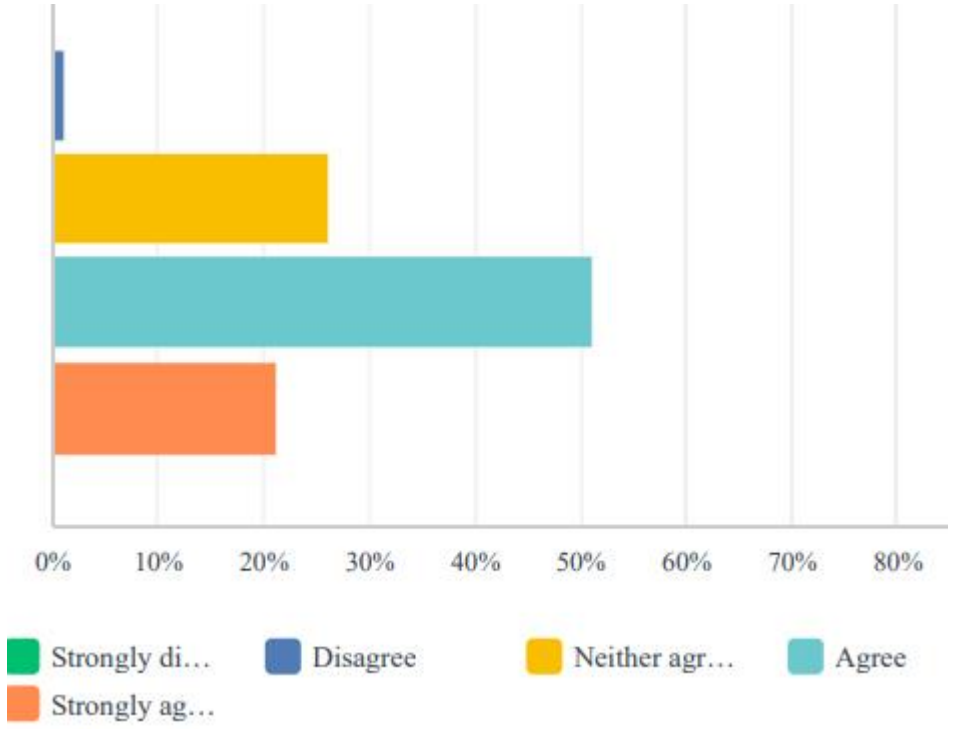


Internalized weight bias can explain some of the variability with weight loss and weight regain after lifestyle changes, medical therapy, or bariatric surgery for obesity.

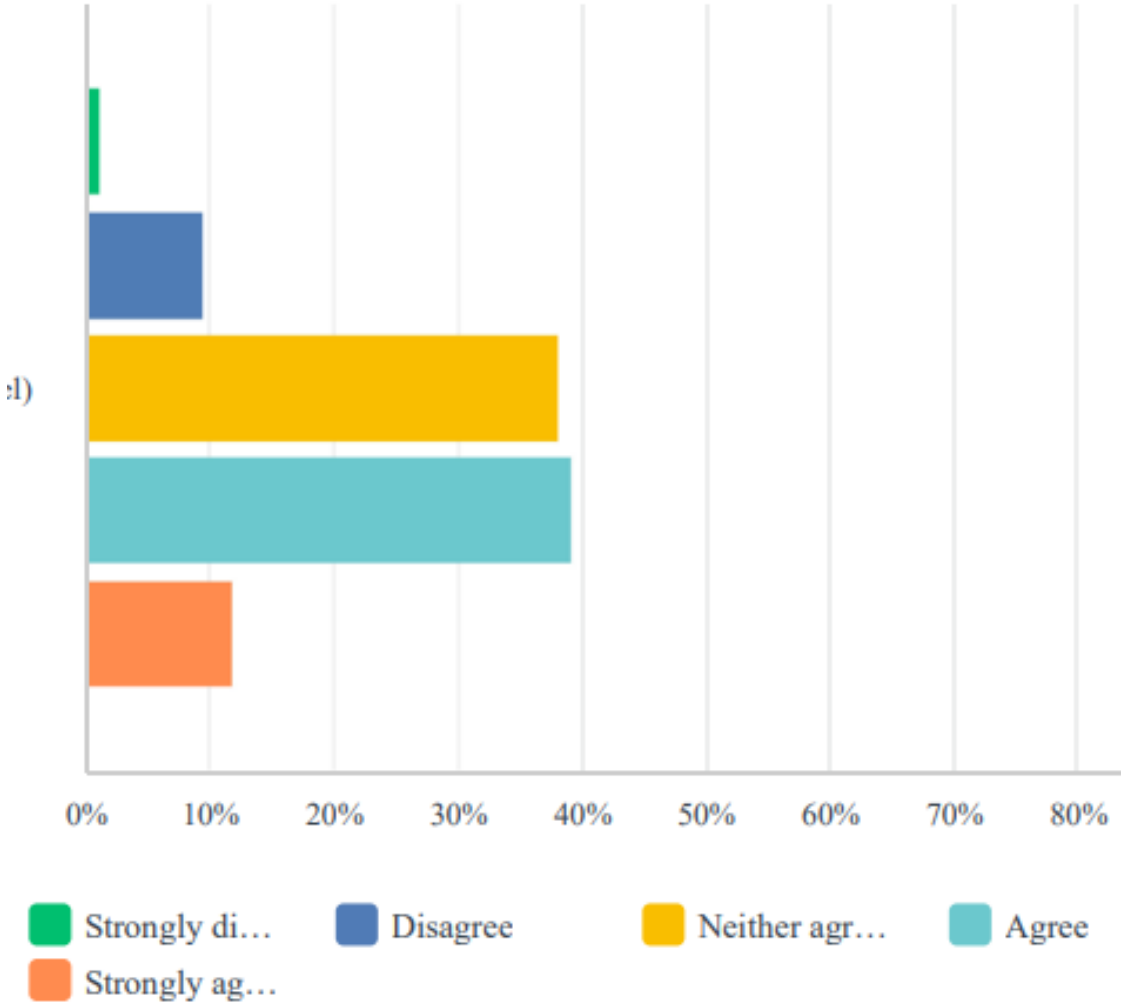


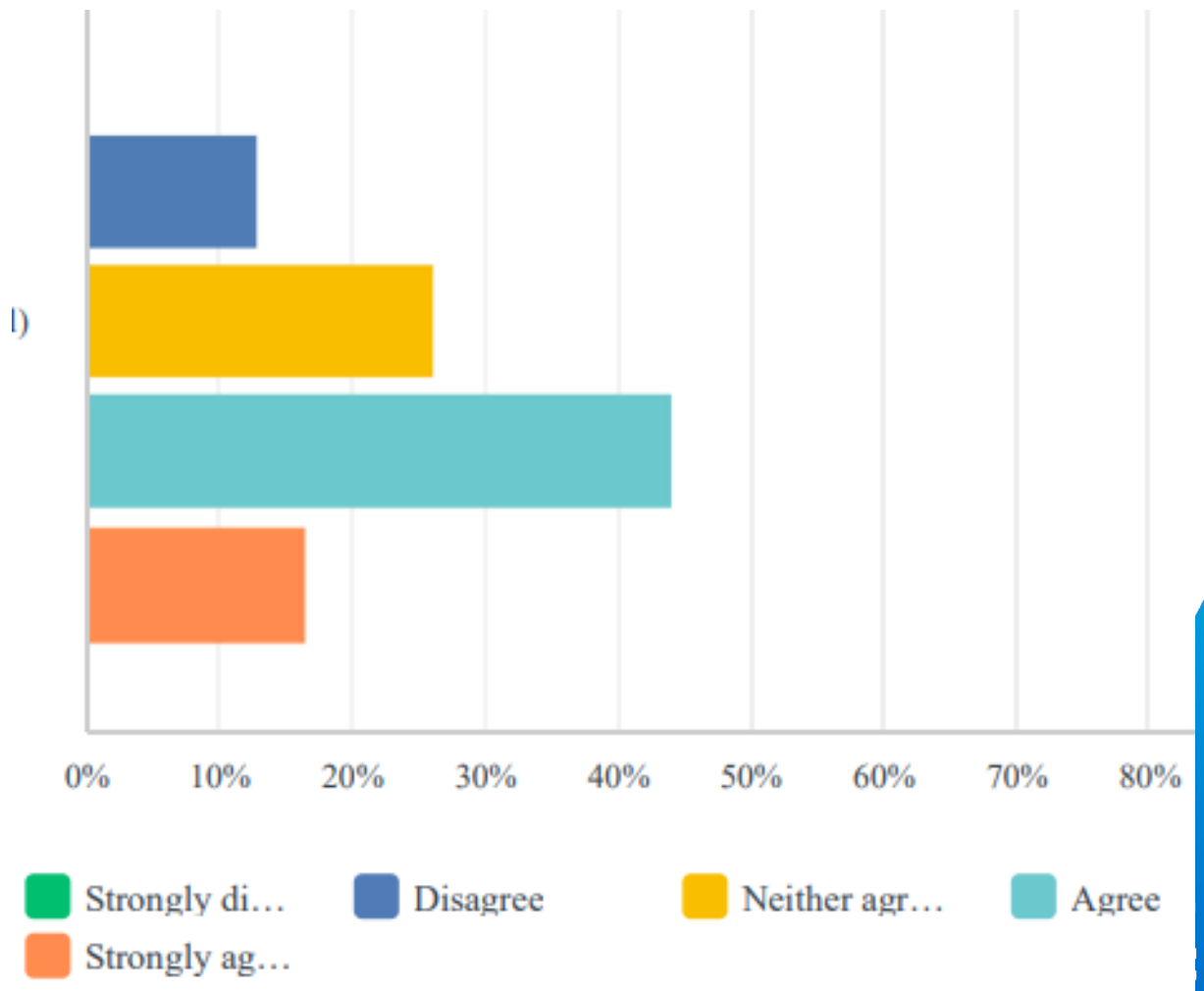
Weight Bias Evaluation

Weight Bias Internalization Scale or similar instruments should be considered to screen patients for internalized weight bias if the initial psychological history suggests weight bias

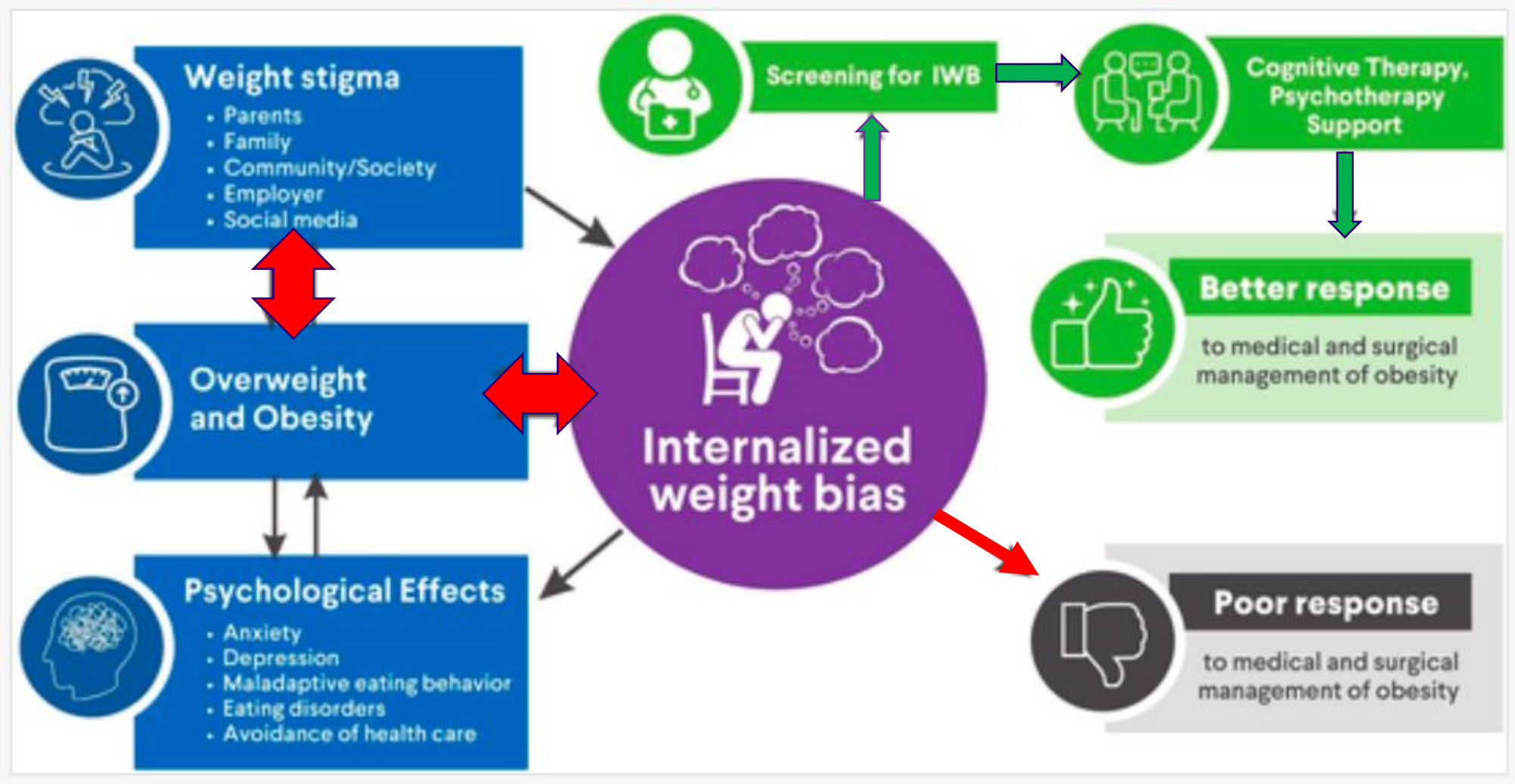


Internalized Weight Bias is Driver & Complication of Obesity





Impact of IWB in the care of persons with obesity.



Nadolsky, et al. Endocrine Practice 2023

AACE 2023

Comparing Self-Report Measures of Internalized Weight Stigma:
Weight Bias Internalization Scale versus Weight Self-Stigma Questionnaire

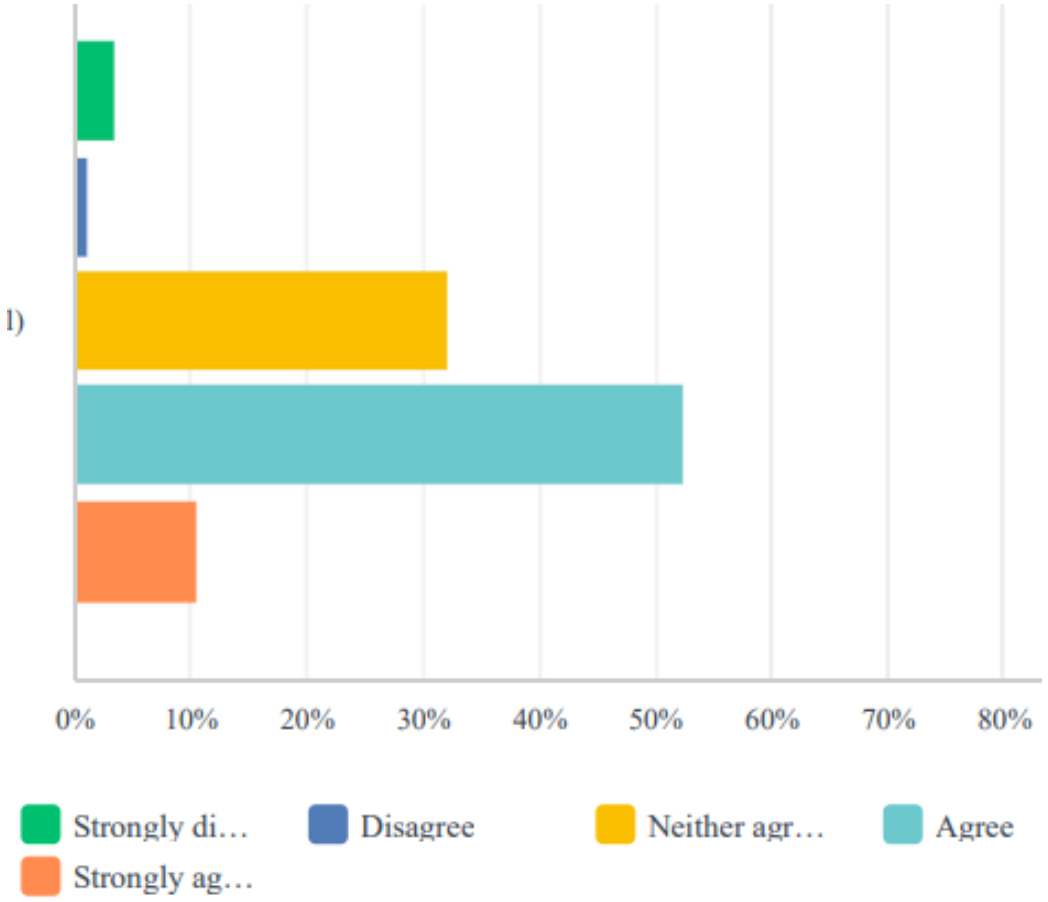
Scale item
1. It's my fault that I am overweight
Outline overweight person, I feel that I am just as competent one[a,b]
3. I am less attractive than most other people because of my weight[b]
4. I feel anxious about being overweight because of what people might think of me[b]
5. I wish I could drastically change my weight[b]
6. If only I had more willpower I wouldn't be the weight that I am
7. Whenever I think a lot about being overweight, I feel depressed[b]
8. I feel that being overweight doesn't interfere with my ability to be a good and decent person[a]
9. I hate myself for being overweight[b]
10. My weight is a major way that I judge my value as a person[b]
11. I don't feel that I deserve to have a really fulfilling social life, as long as I'm overweight[b]
12. I am OK being the weight that I am[a,b]
13. As an overweight person, I feel that I am just as deserving of respect as anyone[a]
14. It really bothers me that people look down on overweight people[a]
15. Because I'm overweight, I don't feel like my true self[b]
16. I feel that being an overweight person does not make me unworthy of a loving relationship[a]
17. Because of my weight, I don't understand how anyone attractive would want to date me[b]
18. I believe that society's prejudice against overweight people is unfair[a]
19. If other people don't treat me with respect, I should put up with it because of my weight

Item
1. I'll always go back to being overweight
2. I caused my weight problems
3. I feel guilty because of my weight problems
4. I became overweight because I'm a weak person
5. I would never have any problems with weight if I were stronger
6. I don't have enough self-control to maintain a healthy weight
7. I feel insecure about others' opinions of me
8. People discriminate against me because I've had weight problems
9. It's difficult for people who haven't had weight problems to relate to me
10. Others will think I lack self-control because of my weight problems
11. People think that I am to blame for my weight problems
12. Others are ashamed to be around me because of my weight

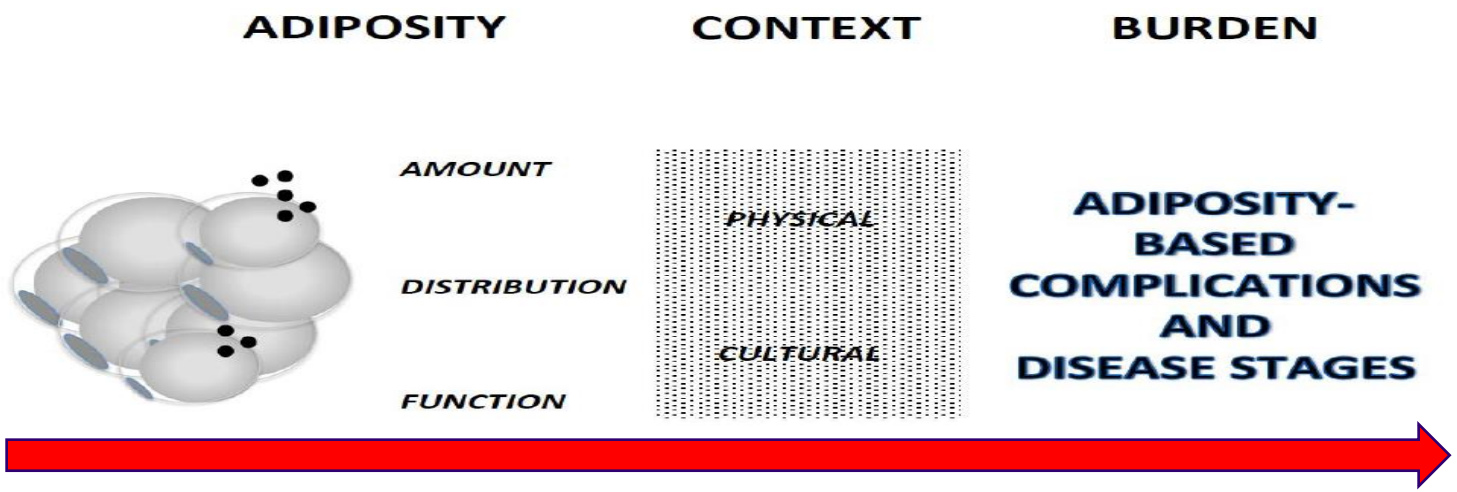
Lillis J, et al. Obesity (Silver Spring). 2010;18(5):971e976
Pearl RL, et al. Body Image. 2014;11(1):89-92
Hubner C, et al. PlosOne 2016;11(10):e0165566
Rossi AA, et al. Eat Weight Disord. 2022;27(7):2459-2472

Internalized Weight Bias Diagnosis / Staging

Internalized weight bias can be diagnosed and its severity staged within the ABCD paradigm.



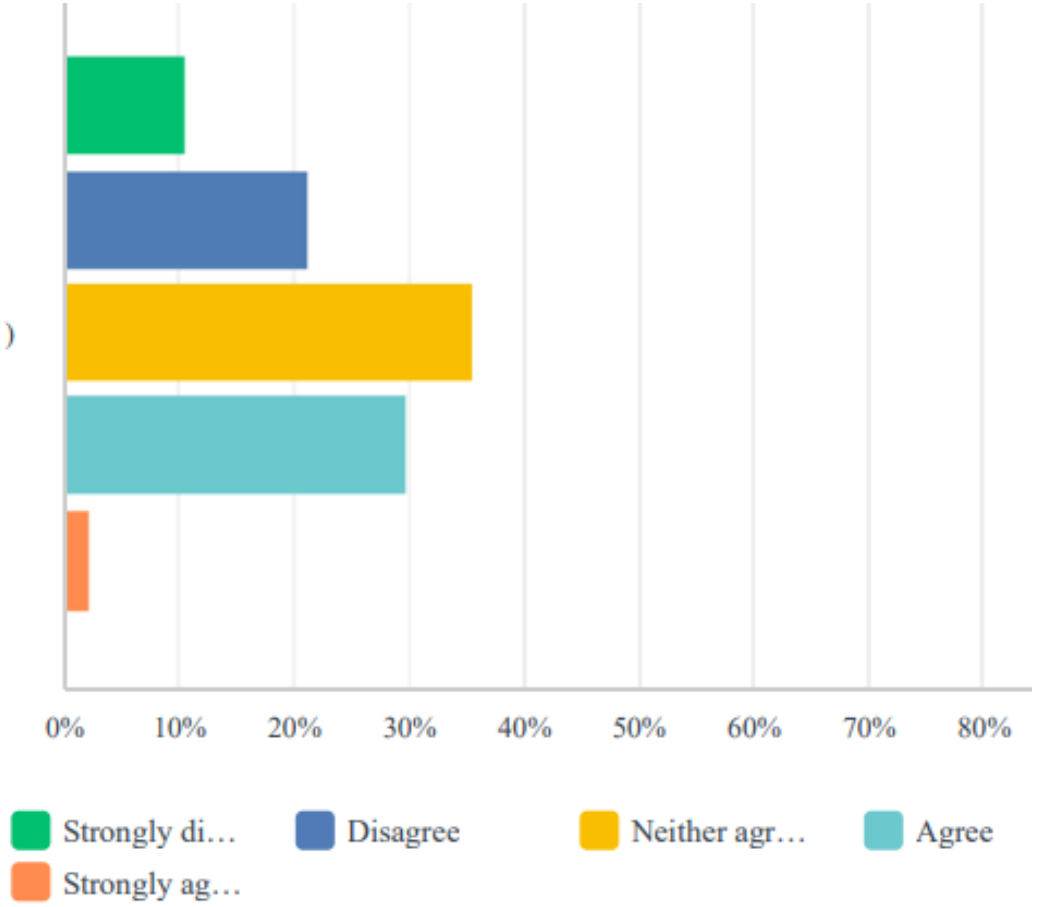
ABCD Staging



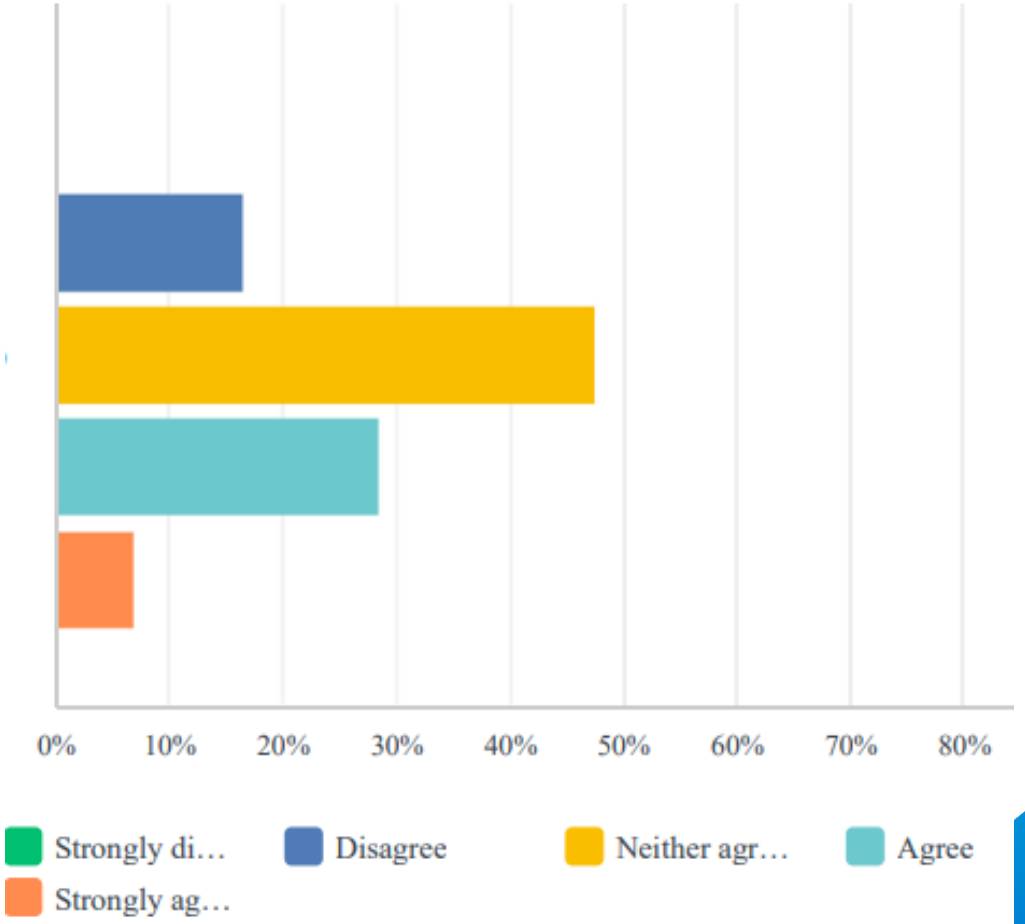
Mechanick JI, et al. Endocr Pract. 2017; 23(3):372-378.

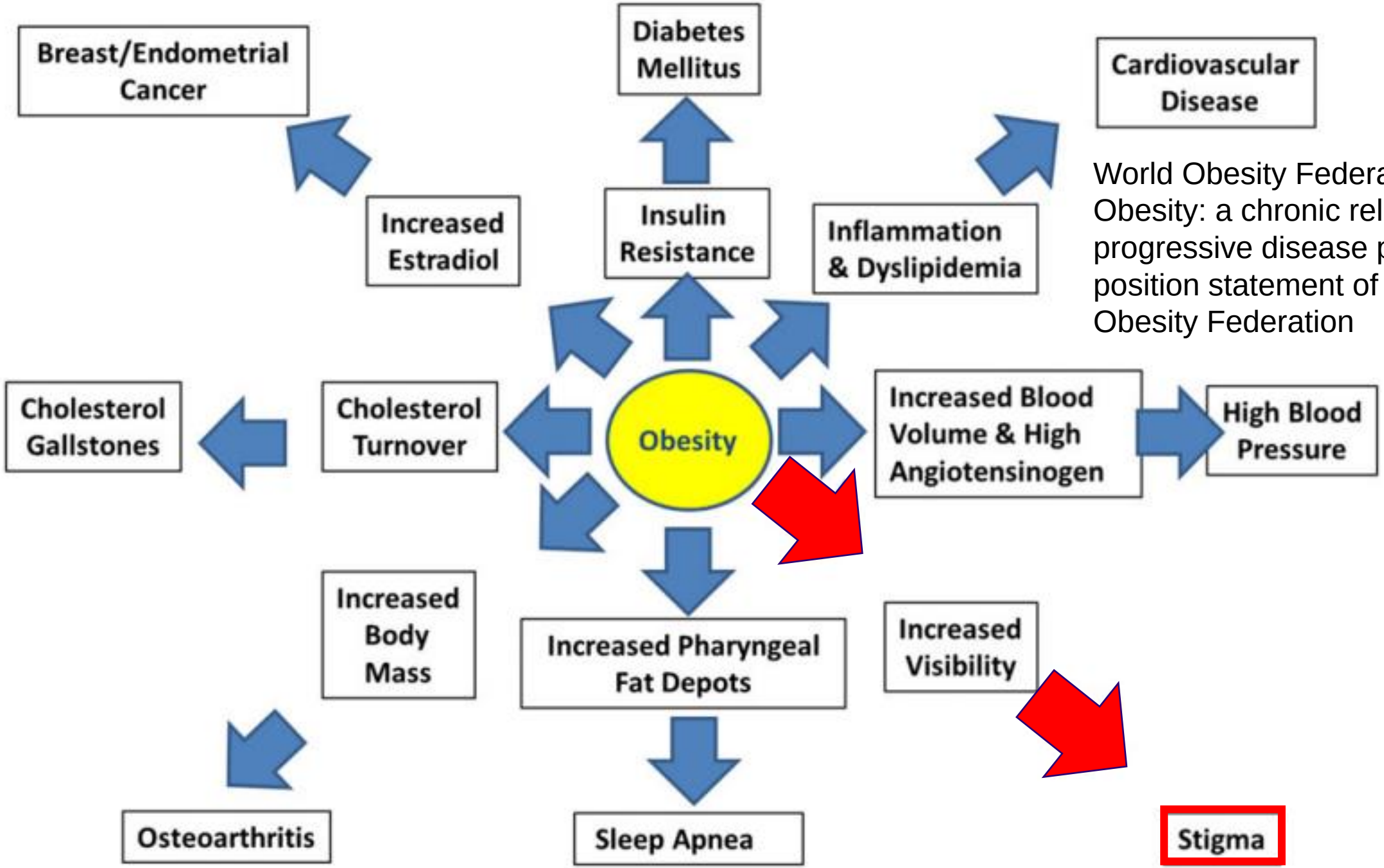
Healthcare Professional Bias

The explicit bias towards obesity is decreasing among healthcare professionals in the US



The implicit bias towards obesity is increasing among healthcare professionals due to increasing awareness and measurement of implicit bias in recent years





World Obesity Federation. Obesity: a chronic relapsing progressive disease process. A position statement of the World Obesity Federation

Bray GA,. Obes Rev. 2017;18(7):715-723

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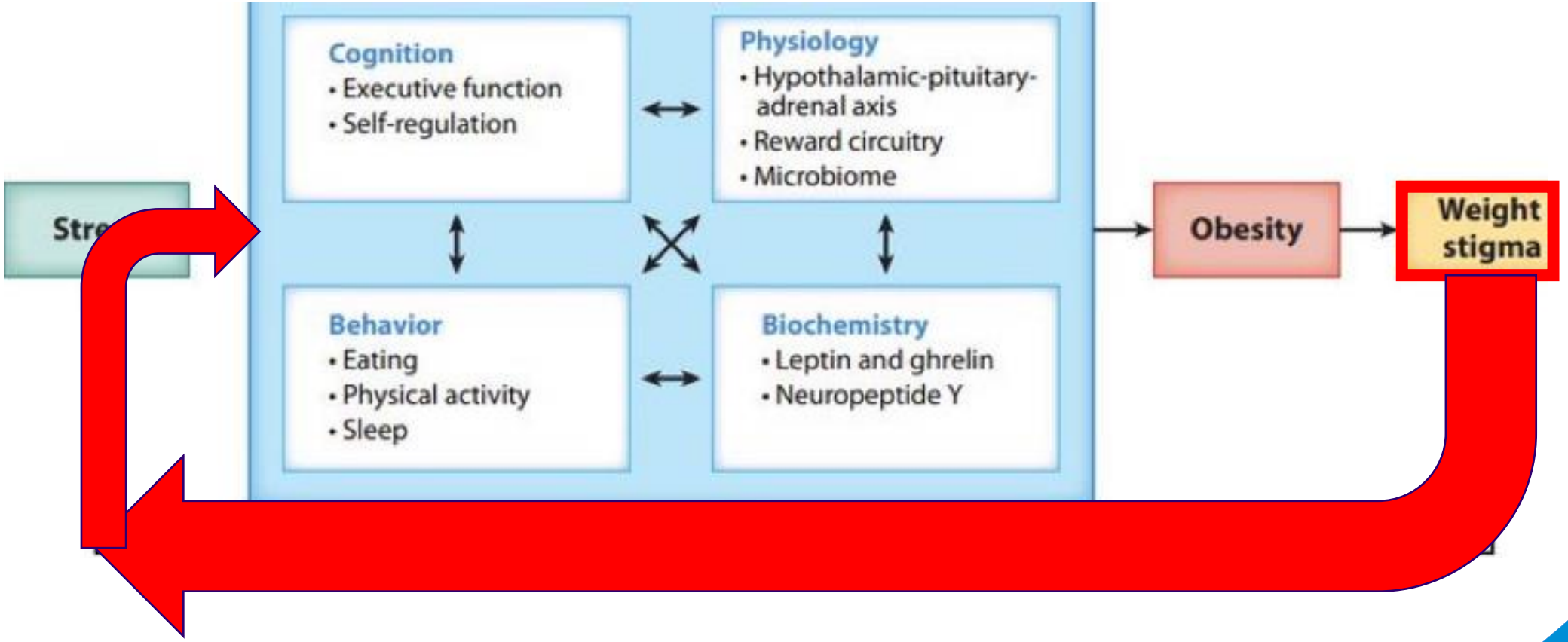
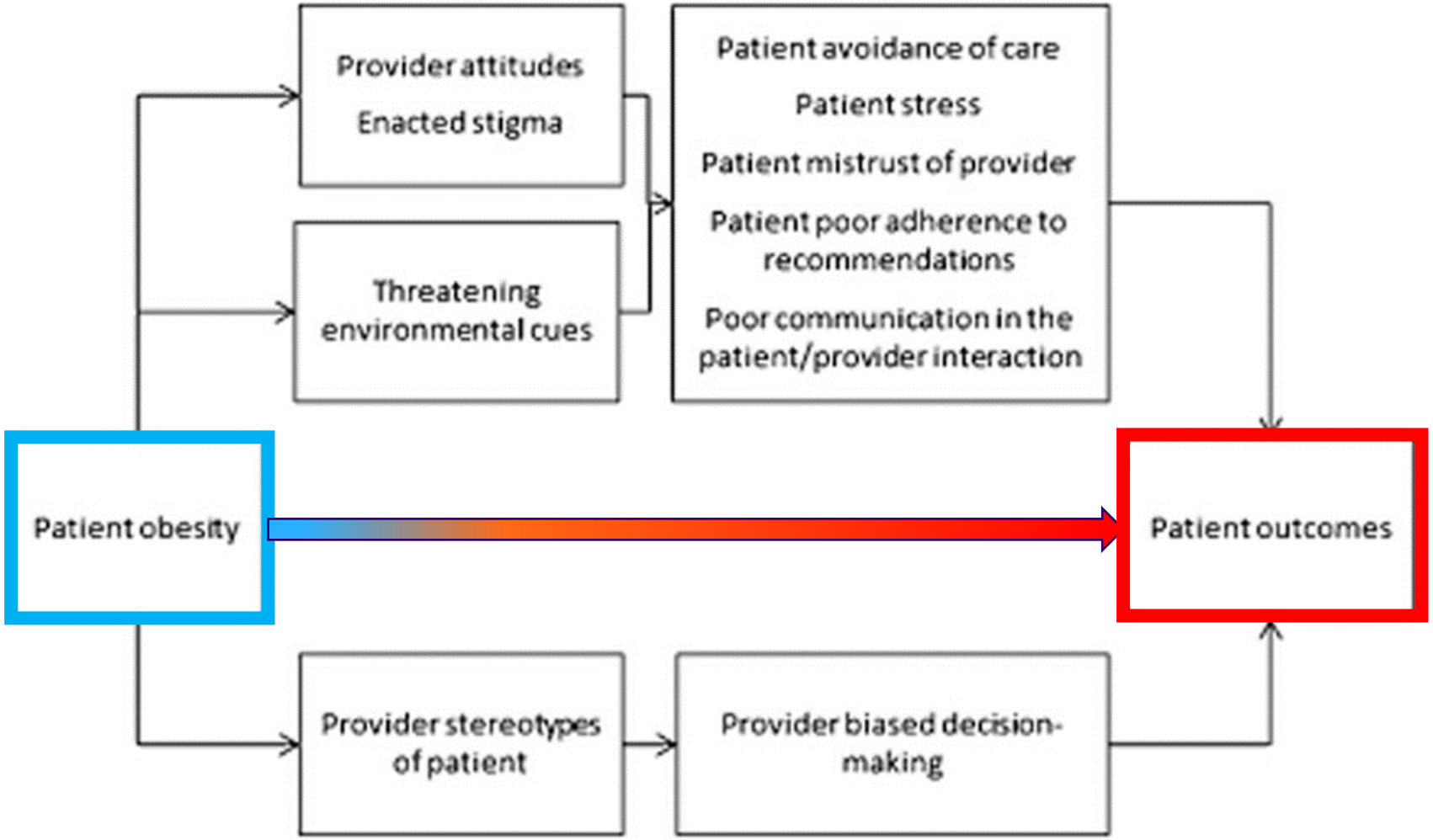
Interactions Among Systems



Tomiyama AJ. Annu Rev Psychol. 2019;70:703-718

Obesity Stigma & Outcomes

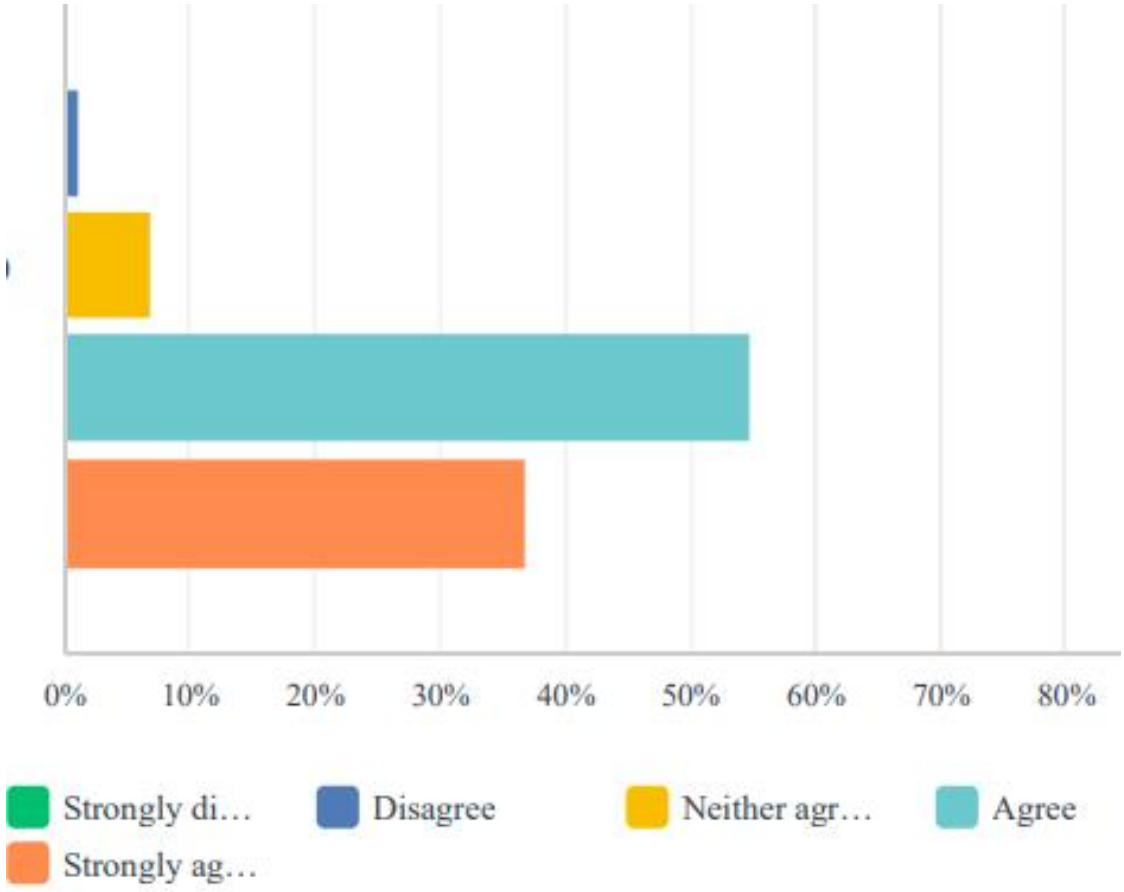
- Conceptual model of hypothesized pathways
- Associations between obesity and health outcomes
- Partially mediated by
  - healthcare providers' attitudes & behaviors about patients
  - patients' response to feeling stigmatized



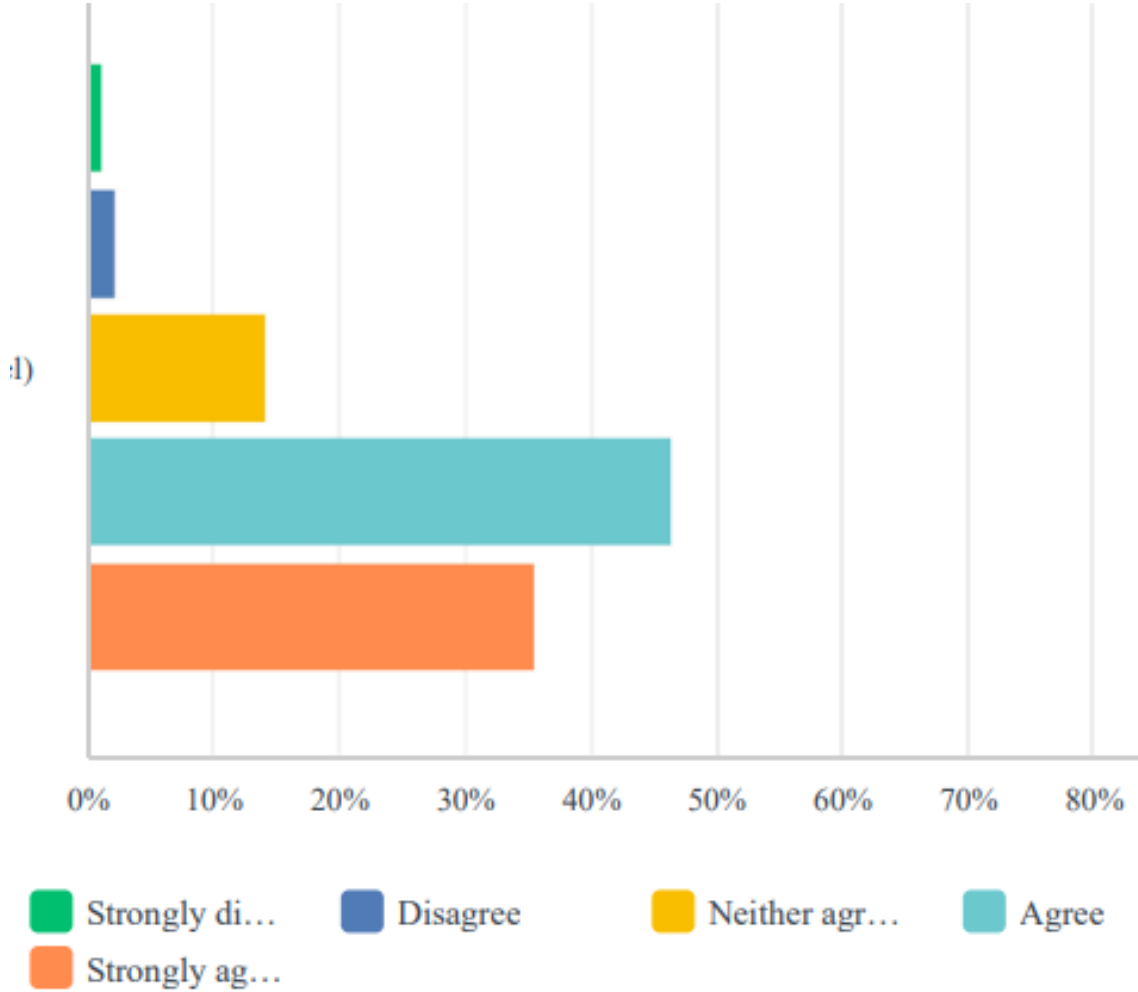
Phelan SM, et al. Obes Rev. 2015;16(4):319-26

Education & Action

Educational tools and curricula about weight bias and stigma are the foundational steps necessary for increasing awareness and mitigating it in clinical settings (inpatient and outpatient settings).



Primary care physicians and primary care teams have the greatest role in addressing weight bias in the healthcare setting



Interaction of Biopsychosocial Determinants

Psychological stress and biological drivers (increased cortisol, decreased self-regulation) are associated with SDOH and may increase the likelihood of weight gain and weight regain.

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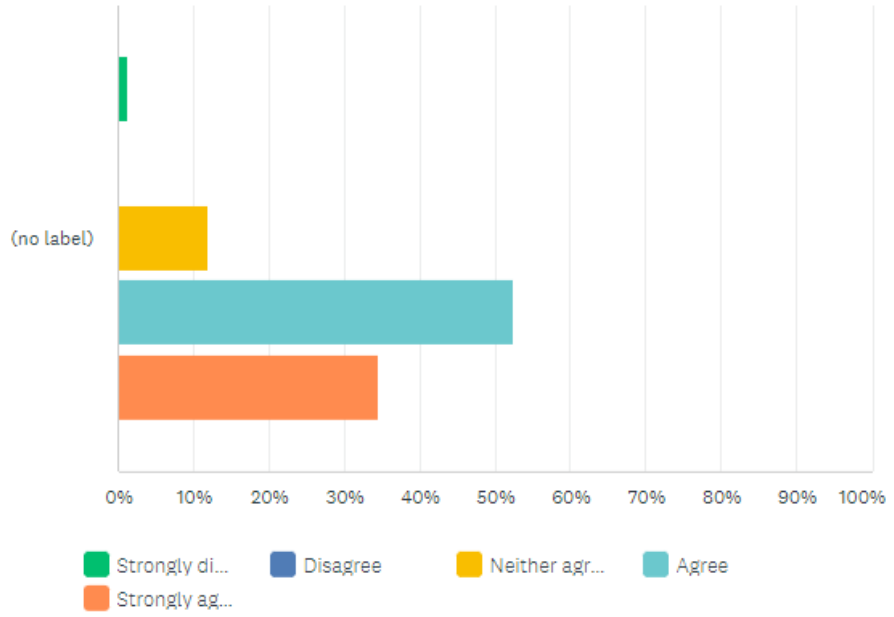

Biological (genetics, epigenetics), psychological (stress, anxiety), social factors (family support, living environment, poverty), and their complex reciprocal interactions drive weight gain and weight regain in patients with overweight/obesity.

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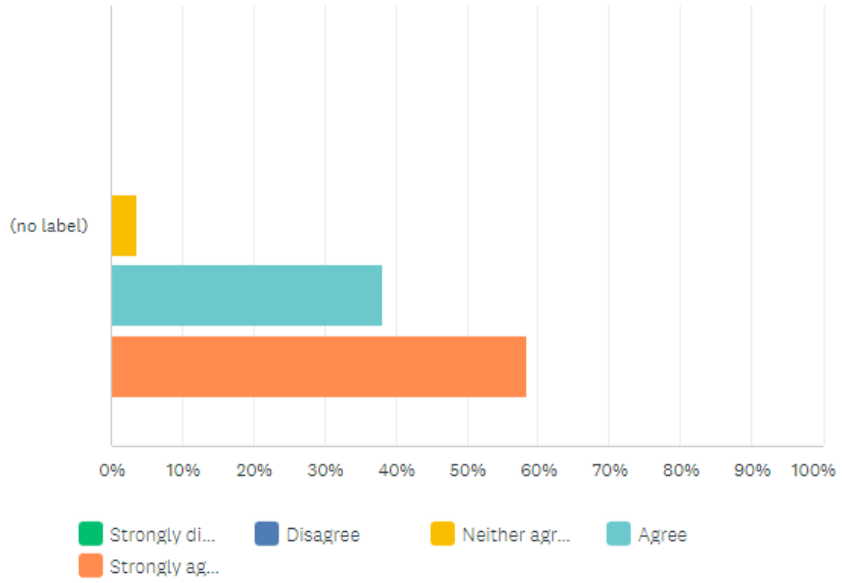

Interaction of Biopsychosocial Determinants

The psychological domain includes emotional, motivational, attitudinal, and behavioral factors that affect health and weight. Therefore, the psychological drivers of obesity should be addressed for the holistic treatment of overweight/obesity.

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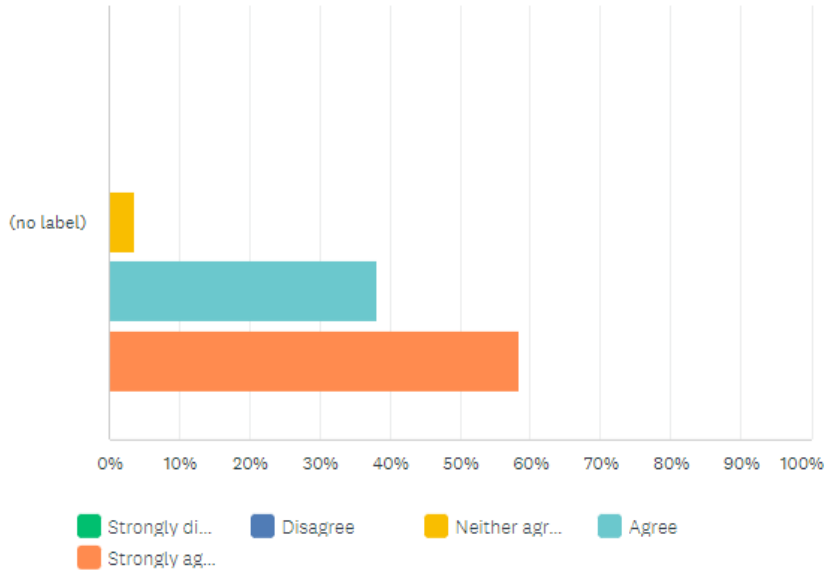

Acknowledging the biopsychosocial model of health and obesity will increase awareness and acceptance of the role of weight bias as a cause and complication of obesity.

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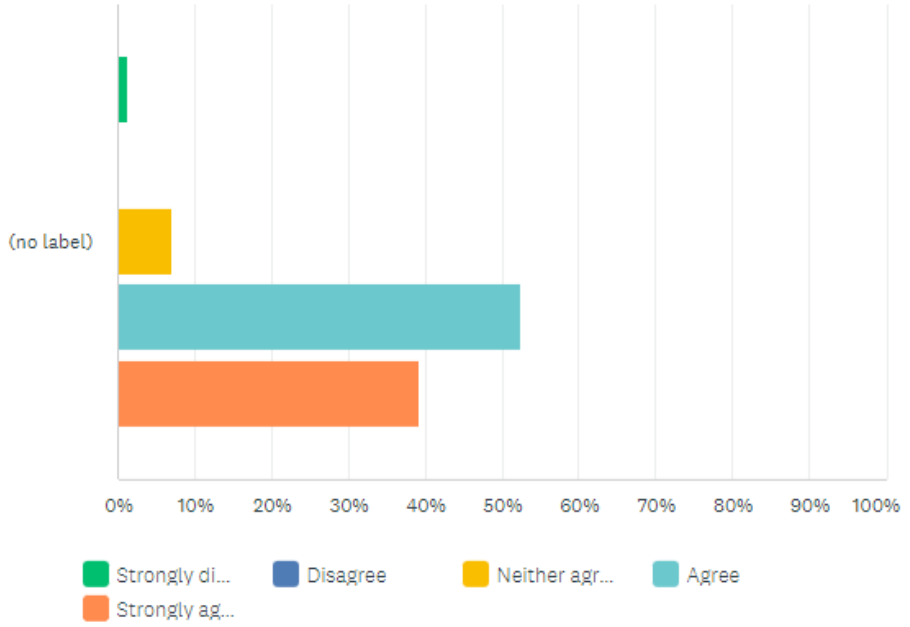
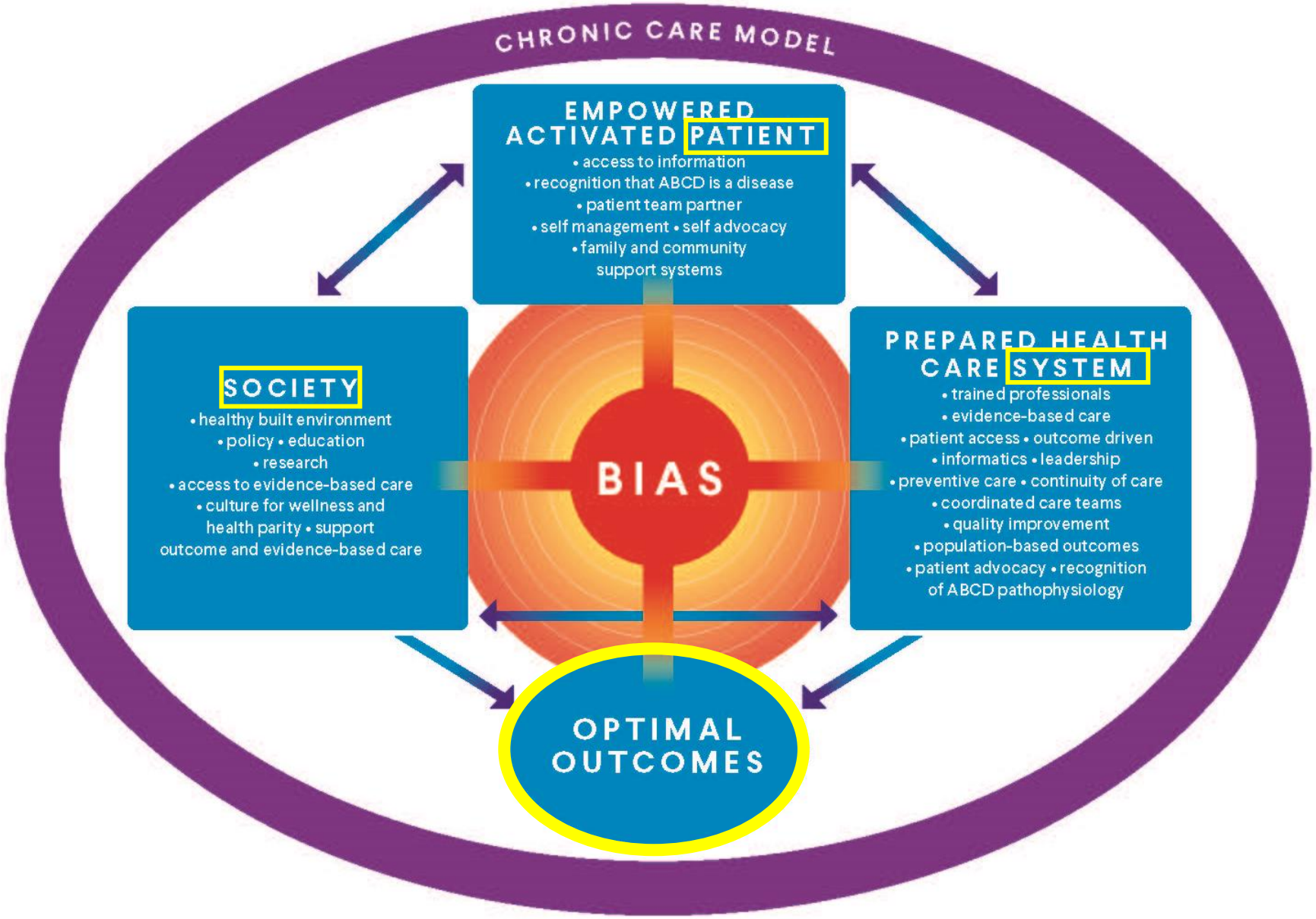


Bias and the Chronic Care Model for ABCD



Nadolsky K, et al. Endocrine Practice 2023

Biopsychosocial Model

- Applicable to obesity
  - Adiposity-based Chronic Disease
- Complex interconnection
  - Biological
  - Psychological
  - Social Factors

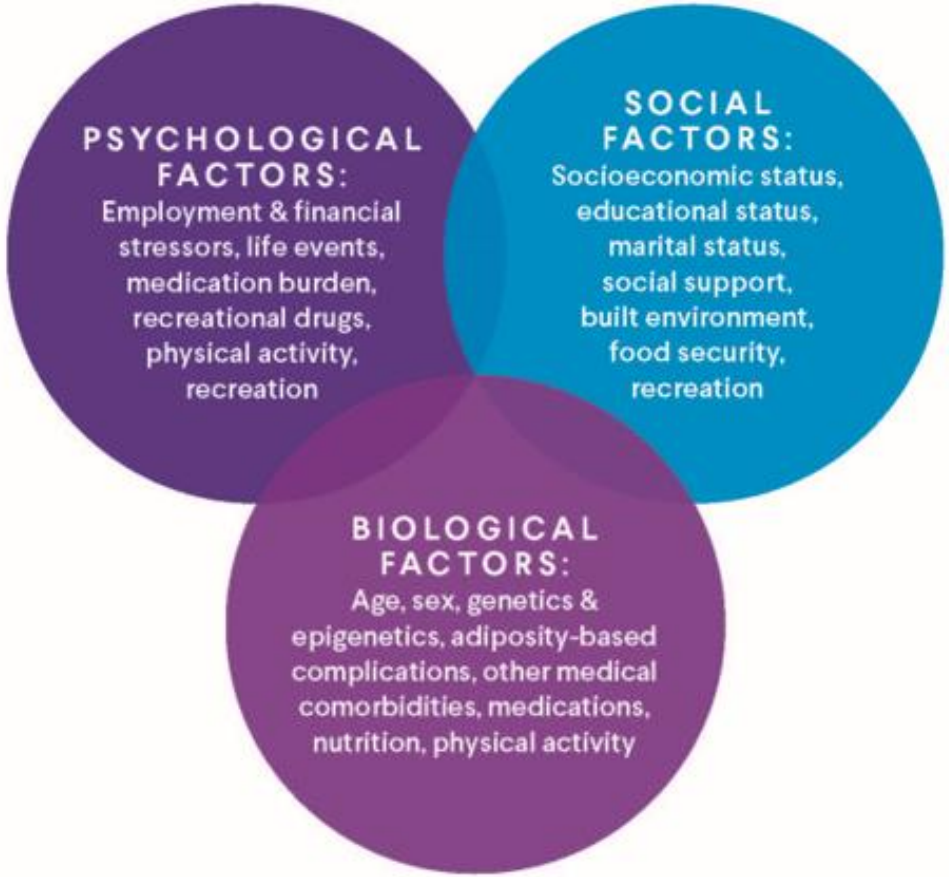


Figure 3. Biopsychosocial model for Obesity/ABCD. First conceptualized by George Engel in 1977,[32] the model was adapted to reaffirm that obesity/ABCD results from the complex interplay of psychological and social factors in addition to biological factors.

Engel GL. *Science*.1977;196(4286):129-36
Nadolsky K, et al. Endocrine Practice 2023

Affirmed & Emergent Concepts

Affirmed Concepts

- Obesity is a complex disease due to multifaceted pathophysiology associated with weight bias & stigma
- Obesity is not a choice, but lifestyle efforts are critical and require education + supportive therapy
- BMI-centric diagnosis is not appropriate on its own
  - Clinical exam + evaluation should be used in context of BMI
- Complication-centric staging of obesity severity is more precise
  - For personalized clinically therapeutic intensity
- Patients with obesity suffer internalized bias
  - Plus implicit & explicit bias among healthcare professionals

Emergent Concepts

- Ethnic-specific BMI classification of individual obesity diagnoses requires improved semantic categories
- ABCD staging requires criteria consensus
- Bias & stigma should be part of mental health screening
  - depression, anxiety, disordered eating + bias/stigma seem bidirectional
- Clinical response to therapy rather than weight loss, per se
  - Preferred and may reduce stigma of weight-centric emphasis
- Internalized weight-bias is cause & complication of ABCD

Incorporation of Bias and Stigmatization, Psychological Health, and Social Determinants of Health in the Staging of ABCD Severity

Previous ABCD Staging

Stage 0-2 based upon severity of complications

STAGE 0	STAGE 1	STAGE 2
No complications	One or more mild-to-moderate complications or may be treated effectively with moderate weight loss	At least one severe complication or requires more aggressive weight loss for effective treatment
+ Risk of other complications		

Proposed ABCD Staging

Stage 1-3 based upon severity of complications
(including IWB/Stigma)

Stage 1	Stage 2	Stage 3
No complications	One or more mild-to-moderate complications or may be treated effectively with moderate weight loss	At least one severe complication or requires more aggressive weight loss for effective treatment
+ Risk of other complications		
IWB/stigmatization, psych, & SDoH operative to degree w/o adverse effects on QoL	IWB/Stigma, psych, or SDoH are present w/ adverse effects on QoL or may impair treatment plan.	IWB/Stigma, psych, or SDoH are present w/ pronounced AE on QoL or may render treatment plans ineffective or harmful

Garvey, et al. Endocr Pract. 2016;22 Suppl 3:1-203
Nadolsky, et al. Endocrine Practice 2023

Consensus Recommendations

- Stigma & IWB are complications of obesity
  - Presence / degree of weight stigma & IWB should be incorporated into the staging of ABCD severity
- IWB & stigmatization can lead to or exacerbate psych disorders
  - ie depression, anxiety, stress, and disordered eating;
  - Patients with ABCD should be screened and treated for these psychological issues
  - Mental health conditions and social determinants of health should also be incorporated into the staging of ABCD severity
- Health care professionals & organizations should implement policies and actions to reduce the impact of weight bias in patient care
  - Ie implicit bias training for staff, obesity education of health care professionals to reduce explicit bias, use of person-first policies and language in treatment plans and health records, and adoption of the new proposed ABCD nomenclature for classification and staging of obesity along with clinical goals of therapy
- Health care professionals and organizations should advocate for improved access to evidence-based treatment modalities and increased research into practice-based solutions to limit the impact of IWB on management of ABCD

Obesity Classifications

Class	BMI Ethnic criteria	WC criteria
Sarcopenic	< 25 kg/m^2 (< 23 Asian)	Population Male Female Caucasian/AA: 94 cm 80 cm Asian/S Am: 90 cm 80 cm
Class 0	25-29.9 kg/m^2	
Class I	30-34.9 kg/m^2	
Class II	35-39.9 kg/m^2	
Class III	≥ 40 kg/m^2	

Degree of adiposity is on a ***continuum***;

Adiposity-based Stigma & IWB Severity

Severity of ABCD is on a ***continuum***

Clinical Response to therapy is priority
Weight reduction is surrogate for outcomes

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Discussion