SEPT 2020

Weight Inclusive Care

The Health At Every Size Approach

Jessica Campbell

Clinic Director, Body Balance Nutrition & Dietetics

5Y Medical Student, Christchurch, University of Otago.

Overview

- Compare and contrast a weight-normative and weight-inclusive approaches in healthcare.

- Critique BMI as a determinant of health and intentional weight loss as a health promoting intervention.

- Review the evidence to support the use of a non-diet approach for well-being and introduce the concepts of Health At Every Size® (HAES®) .

But first, Language

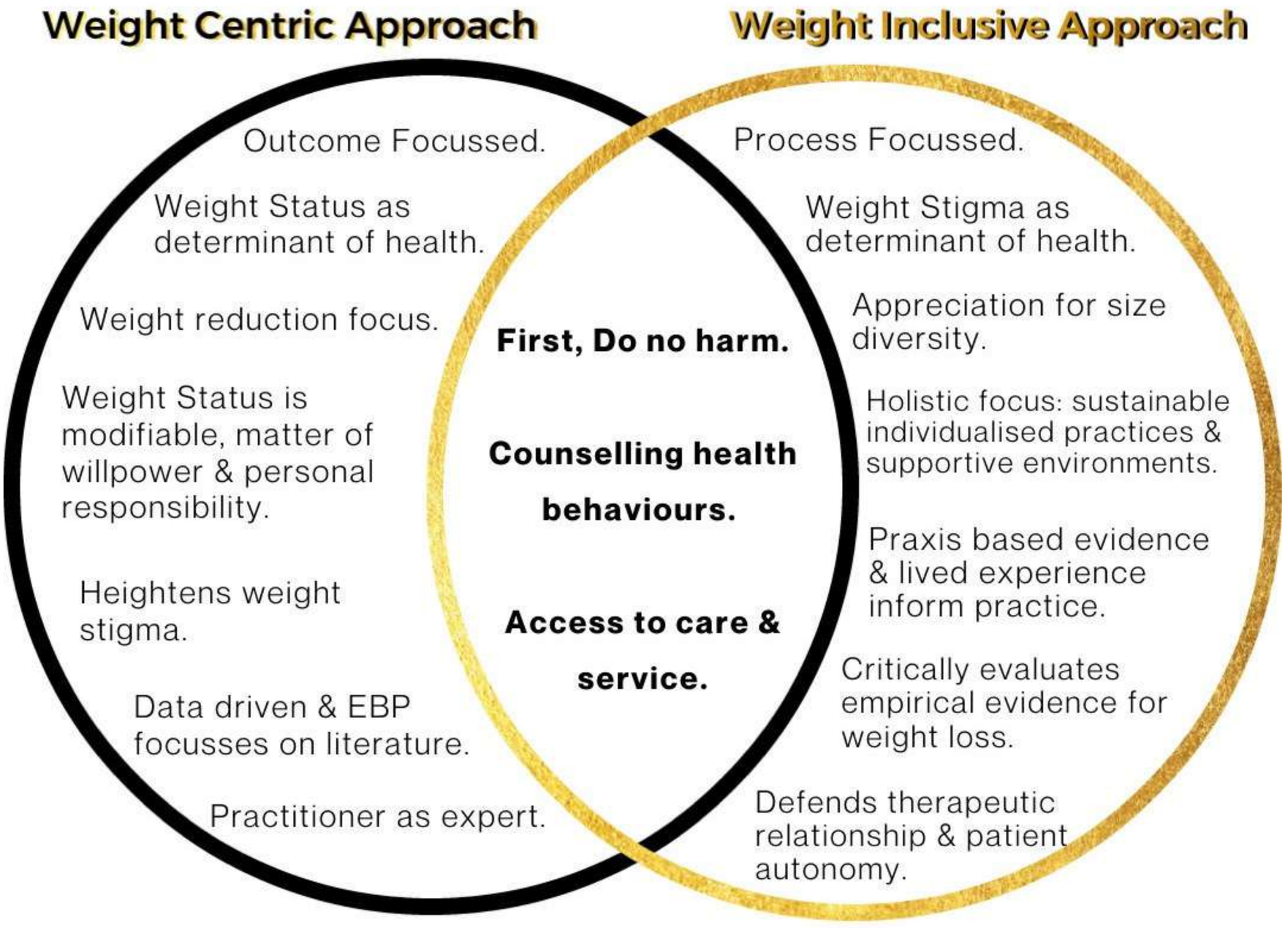
The terms we use to describe bodies in conversation and documentation matters.

There are connotations of descriptors such as overweight & obese.

Obese / Obesity implies disease - depending on where you practice in the world "obesity" is a statistically defined medical diagnosis irrespective of physiological disease state.

Fat - there has been a move toward reclaiming as a neutral descriptor. It remains for some a term that carries profound shame and stigma.

Where required, record BMI numerically, terms such as "higher weight", "larger bodied" may be substituted in documentation.


Weight Centric Approach
Weight Inclusive Approach
Outcome Focussed.
Weight Status as determinant of health.
Weight reduction focus.
Weight Status is modifiable, matter of willpower & personal responsibility.
Heightens weight stigma.
Data driven & EBP focusses on literature.
Practitioner as expert.
First, Do no harm.
Counselling health behaviours.
Access to care & service.
Process Focussed.
Weight Stigma as determinant of health.
Appreciation for size diversity.
Holistic focus: sustainable individualised practices & supportive environments.
Praxis based evidence & lived experience inform practice.
Critically evaluates empirical evidence for weight loss.
Defends therapeutic relationship & patient autonomy.

Weight Normative Care

- Paradigm health professionals are traditionally trained in (that's us!).
- Refers to the many principles and practices of health care and health improvement that prioritise weight as a main determinant of health.
- Weight management (i.e., weight loss and weight cycling) is a central component irrespective of presentation if BMI >30.
- Emphasises personal responsibility for “healthy lifestyle choices” and the maintenance of “healthy weight”

Weight Normative Care – Critical Perspectives

- Based on the widely held belief that BMI is causally associated with negative health outcomes and that weight loss is widely achievable.

- Reinforces weight stigma.

- Reinforces weight bias in care providers.

- Promotion of “healthy weight” as the key to health and well-being is counterproductive to achieving a persons health aspirations.

- Not offering or inadequate informed consent when providing weight loss advice.

Weight Normative Care – impact:

Healthcare Users:

- Frustrated
- Unheard
- Invalidated
- Stigmatised
- Medically marginalised
- Harmed

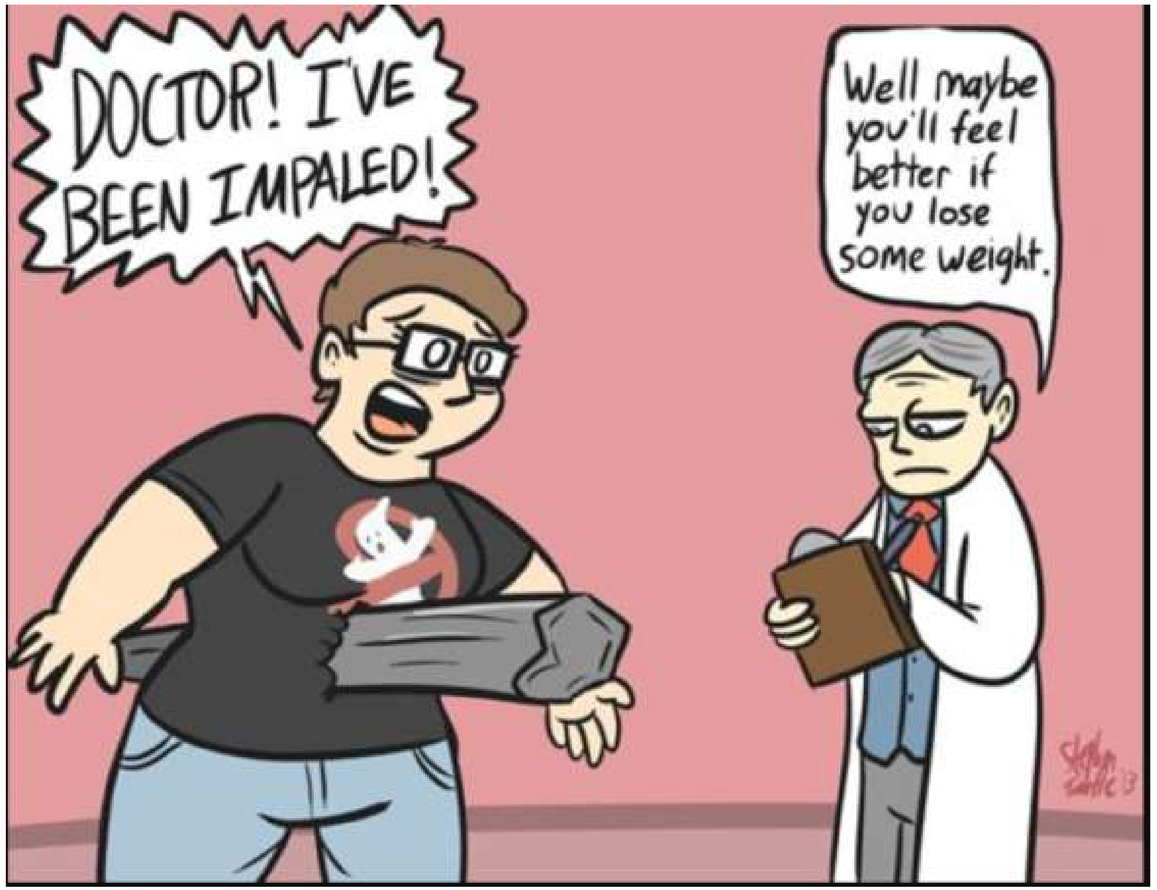
These things are bad for health outcomes.

Healthcare Providers:

- Frustrated
- Recognising: the futility of weight loss as a health gain intervention

- Contributes to moral injury & burnout
- Recognising: harm & injustice of weight based treatment and restrictions on access to higher levels of care

Weight Bias is a Health Hazard



- **Diagnostic over shadowing**, delayed diagnosis, inappropriate or no screening of mental health, eating disorder history or risk assessment prior to delivery of weight loss interventions.
- **Over treatment** - with ineffective interventions, or low threshold for admissions etc
- **Inappropriate medication regimes or treatment protocols** - drugs often trialled and tested on "normal" weight patients so efficacy uncertain / inferred
- **Healthcare avoidance** - delayed presentation, delay diagnosis, poorer prognosis.
- Less time with practitioner, less satisfactory therapeutic alliance (which has a treatment effect!)

5 Assumptions of Weight Centric Care

Assumption 1. Higher Body Weight Equals Poorer Health

- Weight/BMI is frequently associated with adverse health outcomes in the medical science literature.

- Tendency toward "correlation as causation" fallacy.

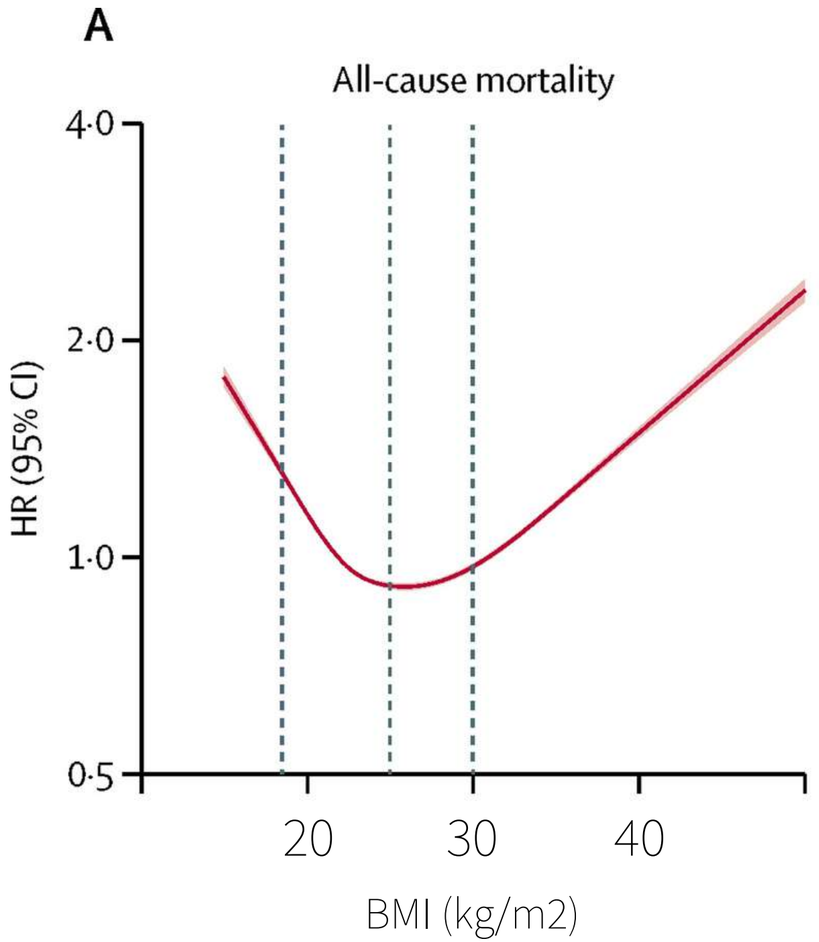
- Ascribing causal role is reductive (and erroneous with the data and study designs), and omits the likely possibility of third variables or reverse causation confounding the relationship between BMI and health outcomes:

  - metabolic dysfunction --> IR (with high BMI a side effect)
  - engagement and access with health behaviours (more on this shortly)
  - other intersecting identities - race, gender, SES etc
  - reverse causation --> poor health begets increased BMI mediated via disability, financial stress, and marginalisation
  - diagnostic overshadowing & medical marginalisation (esp important for mortality)
  - weight stigma, shame
  - repeated attempts at intentional weight loss /weight cycling (Highly predictive of increased BMI with time)

Assumption 1. Higher Body Weight Equals Poorer Health

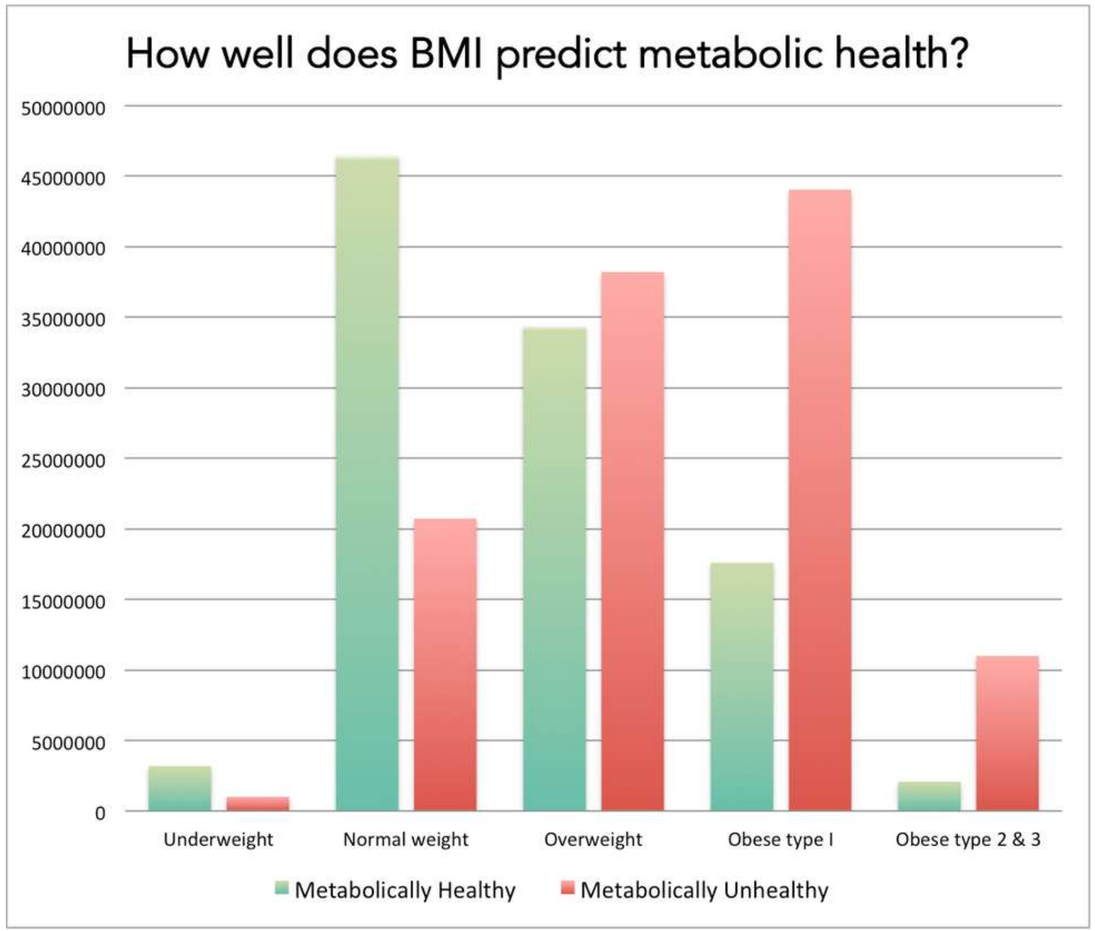
- The evidence points to higher body weight may in fact be a protective factor - so called "obesity paradox" - seen in the U or J shaped HR curves.

- Individuals with a BMI in the “overweight” (and variably “obesity” class I) range appear to have the lowest all-cause mortality rates, across a number of systematic reviews & meta-analysis.



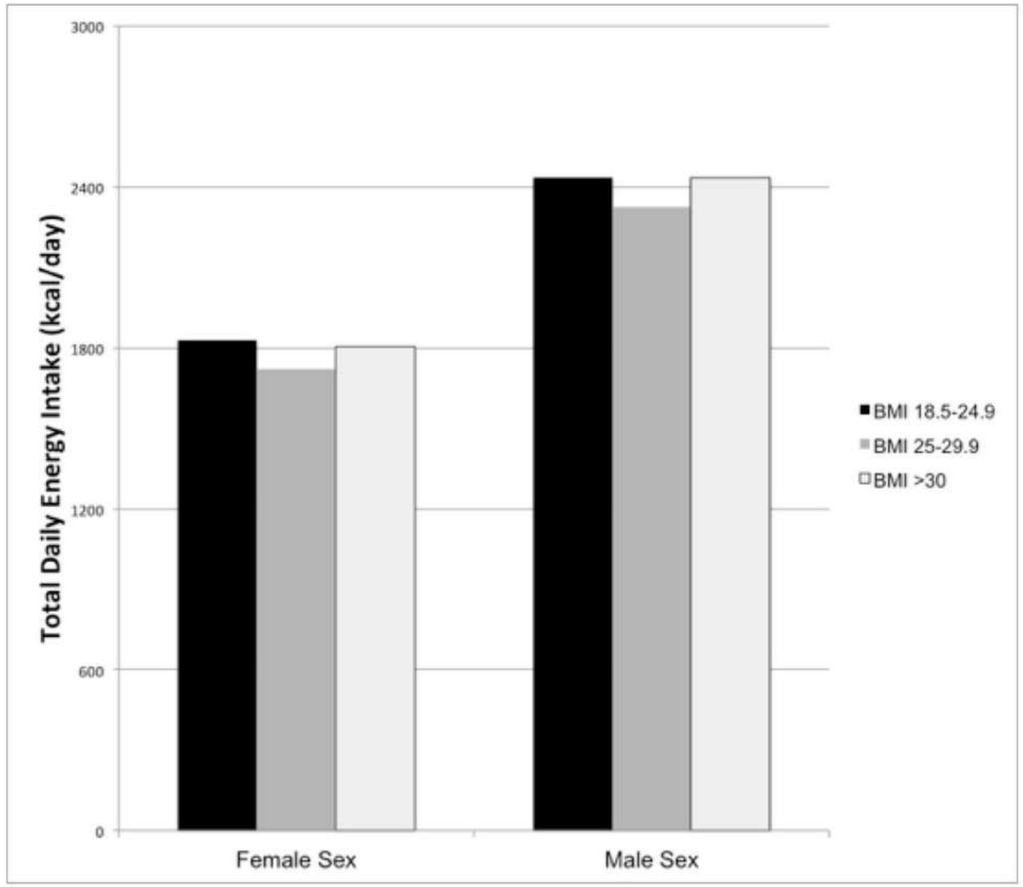
Lancet, 2018. Association of BMI with overall and cause-specific mortality: a population-based cohort study of 3·6 million adults in the UK

Assumption 1. Higher Body Weight Equals Poorer Health



- BMI is not particularly good at at determining metabolically healthy from metabolically unhealthy individuals.
- 2005-2012 NHANES study found that a large proportion of US adults are misclassified as cardiometabolically unhealthy according to BMI categories... we should not rely on BMI when formulating health policy.
- A clinical focus guided by weight and BMI may be misdirected.

Assumption 2. Higher weight people eat more and less healthfully



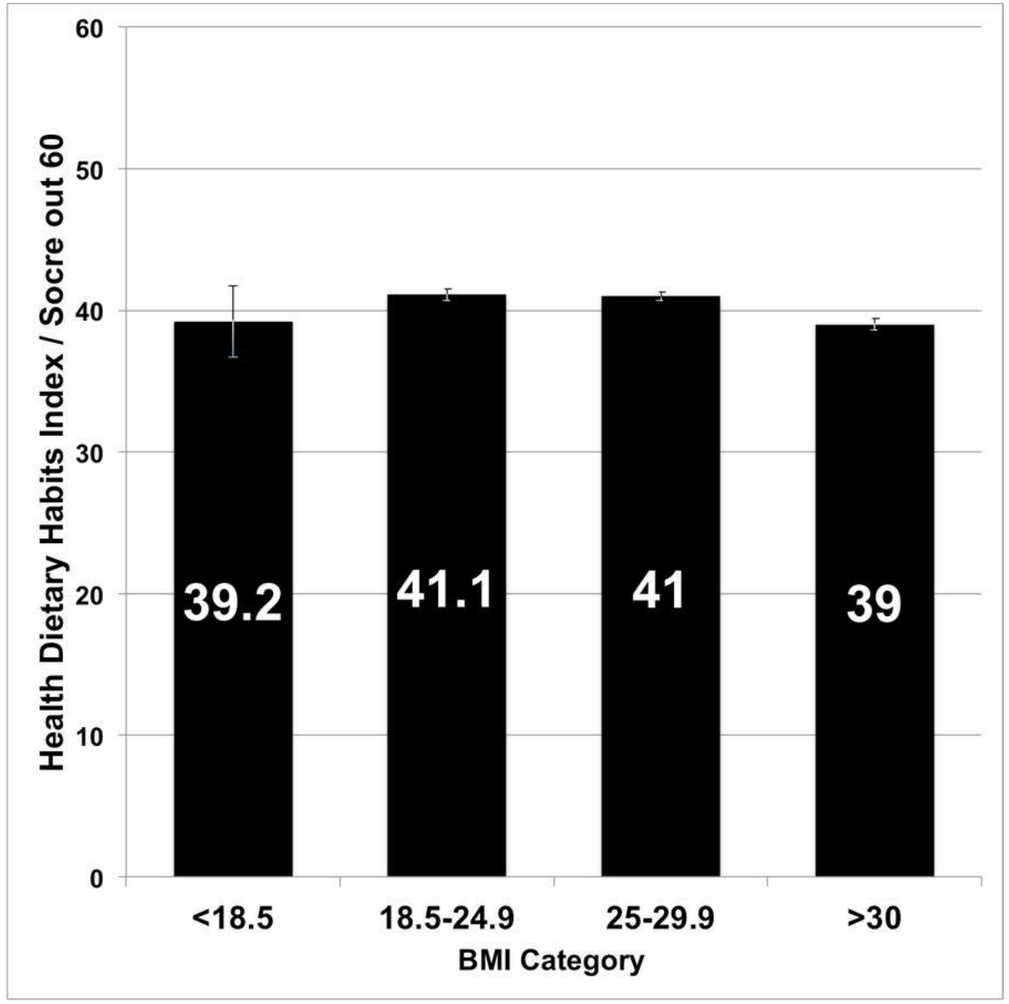
Reference: Drenowatz C, et al. Differences in correlates of energy balance in normal weight, ov rw ight and ob se adults. Obes Res Clin Pract (2015).

Common belief: Higher weight folks consume more calories.

>> There is very little difference in average energy intake across BMI bands >18.5

(Graph shows Total Daily Energy Intake by BMI bands 18.5-24.9, 25-29.9 and >30 by female and male sex).

Assumption 2. Higher weight people eat more and less healthfully



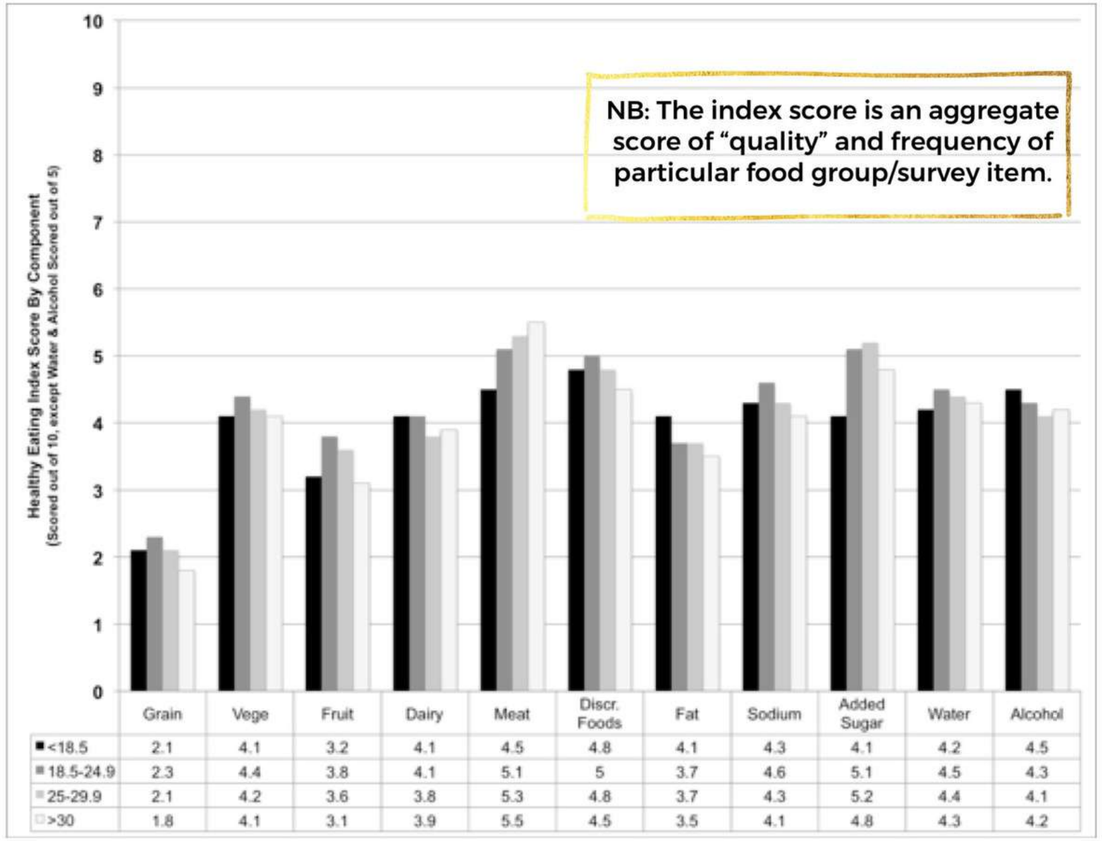
Common belief: higher weight people eat less healthful diets.

A validated Healthy Dietary Habits Index (HDHI) demonstrated the dietary quality in New Zealand Adults is similar across the weight spectrum.

Wong JE, Haszard JJ, Howe AS, Parnell WR, Skidmore PML. Development of a Healthy Dietary Habits Index for New Zealand Adults. Nutrients. 2017;9(5):454. Published 2017 May 3. doi:10.3390/nu9050454

Assumption 2. Higher weight people eat more and less healthfully

Little variation of index score, by food group, across the weight spectrum when we look at the HEIFA-2013 components.



	Grain	Vege	Fruit	Dairy	Meat	Discr. Foods	Fat	Sodium	Added Sugar	Water	Alcohol
<18.5	2.1	4.1	3.2	4.1	4.5	4.8	4.1	4.3	4.1	4.2	4.5
18.5-24.9	2.3	4.4	3.8	4.1	5.1	5	3.7	4.6	5.1	4.5	4.3
25-29.9	2.1	4.2	3.6	3.8	5.3	4.8	3.7	4.3	5.2	4.4	4.1
>30	1.8	4.1	3.1	3.9	5.5	4.5	3.5	4.1	4.8	4.3	4.2

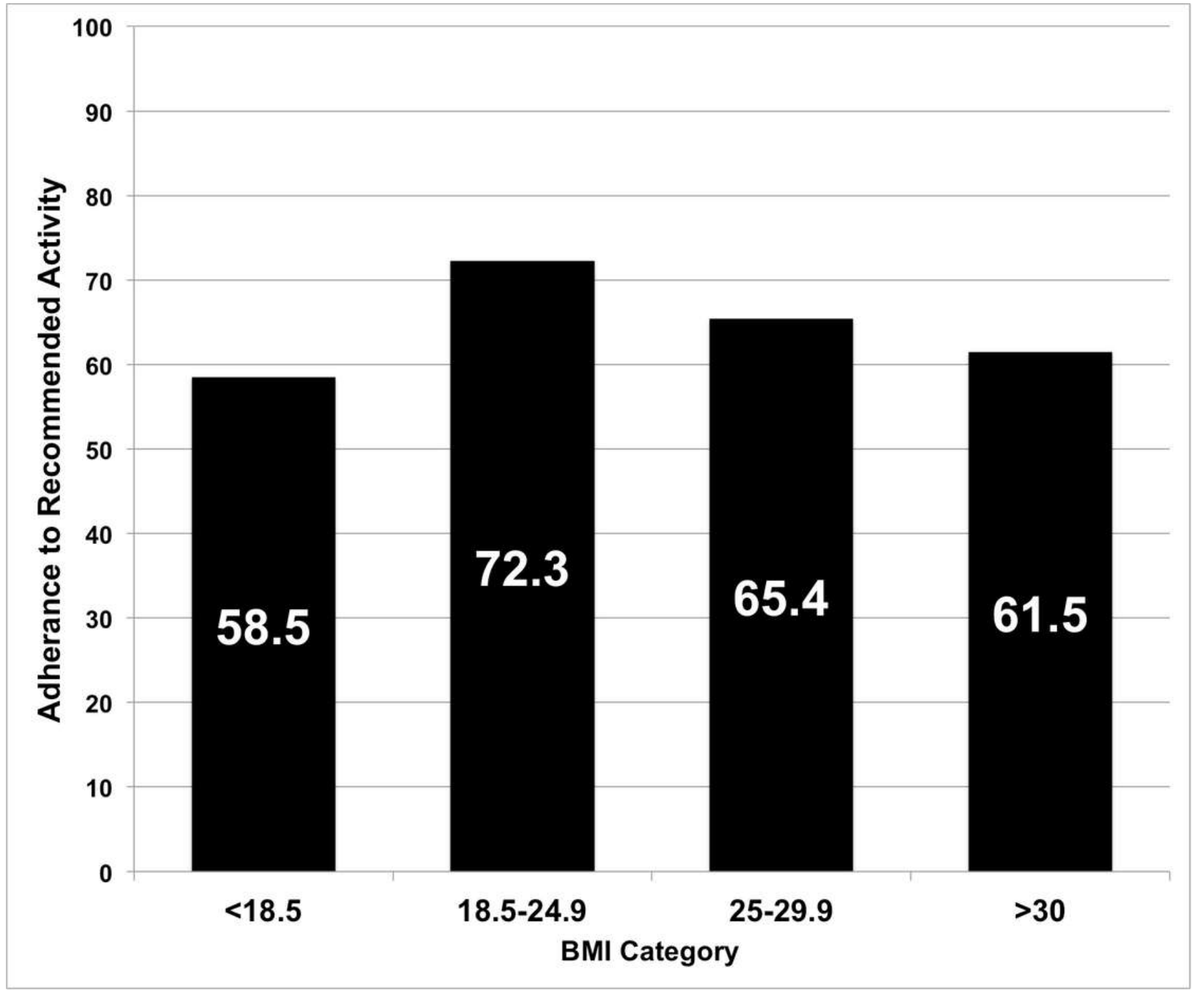
All scored out of 10, except water & alcohol - scored out of 5. Higher the score the "better" the index.

Reference: Grech, Amanda, et al. 2017

Common belief: higher weight people eat a less healthful dietary pattern

When looking more closely at individual food groups & survey items there is little variation by food groups across the weight spectrum.

Assumption 3. Higher weight people are sedentary



- Adherence Rates to the Physical Activity Guidelines for Aerobic Activity in the NHANES Cycle 2016 cycle.

- 65.4% and 61.5% of survey participants in the "overweight" and "obese" categories report meeting the Physical Activity Targets.

Du, Y., Liu, B., Sun, Y., Snetselaar, L. G., Wallace, R. B., & Bao, W. (2019). Trends in adherence to the physical activity guidelines for Americans for aerobic activity and time spent on sedentary behavior among US adults, 2007 to 2016. JAMA network open, 2(7), e197597-e197597.

Assumption 4. Long term weight loss is acheivable

The following are from a 2015 publication in the American Journal of Public Health had reviewed the electronic health records over a 9 year period (2004-2014) for 76,704 men and 99,791 women with BMI >30 to determine the probability of achieving weight reduction via lifestyle in the community setting.

Annual probability of acheiving a 5% weight reduction?

Initial BMI	Men	Women
30-34.9	1 in 12	1 in 10
35-39.9	1 in 9	1 in 9
40-44.9	1 in 8	1 in 7
>45	1 in 5	1 in 6

Assumption 4. Long term weight loss is acheivable

How many folks will regain that 5% weight reduction by 2 years?

50%

What if we seek to lose a greater amount of weight?
Better chance of maintaing the reduction?

Assumption 4. Long term weight loss is acheivable

How many folks will regain a 10% weight reduction by 1 year?

80%

Assumption 4. Long term weight loss is acheivable

If your starting BMI is 30-34.9 the annual probability of acheiving a BMI of less than 24.9 is:

0.48% Male

0.8% Female

If your starting BMI is 40-44.9 the annual probability of acheiving a BMI of less than 24.9 is:

0.077% Male

0.15% Female

Assumption 4. Long term weight loss is acheivable

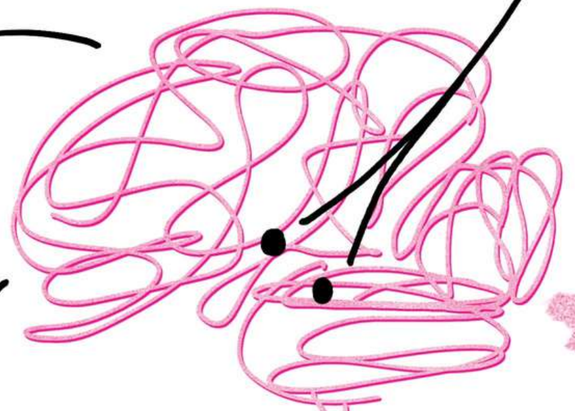
Short term weight loss is achievable - we needn't look far in the evidence base.

However, we see a typical pattern (2013 NHRMC, Level A Evidence Statement):

- Maximal weight loss by 6-12 months.
- Weight gain then commences - irrespective of behaviour change (or maintaining new, lower energy balance).
- Back to baseline by 2-5 years.

The Hungry Brain

Hypothalamus & centre in brainstem mediate changes in appetite hormones:



↓ Satiety Hormones

Hormones signaling we are full/nourished. Leptin, Peptide YY, Cholecytokinin.

↑ Appetitive Hormones

Hormones signaling we are hungry/increase the drive to eat. (Ghrelin, Gastric inhibitory polypeptide [GIP], pancreatic polypeptide).

Enhanced hedonic responses to food.

AKA. Food is extra appealing.

Enhanced memory recall of food.

Activation of brain-reward systems to food.

Think about, notice & pay attention to food more. (Food fixation).

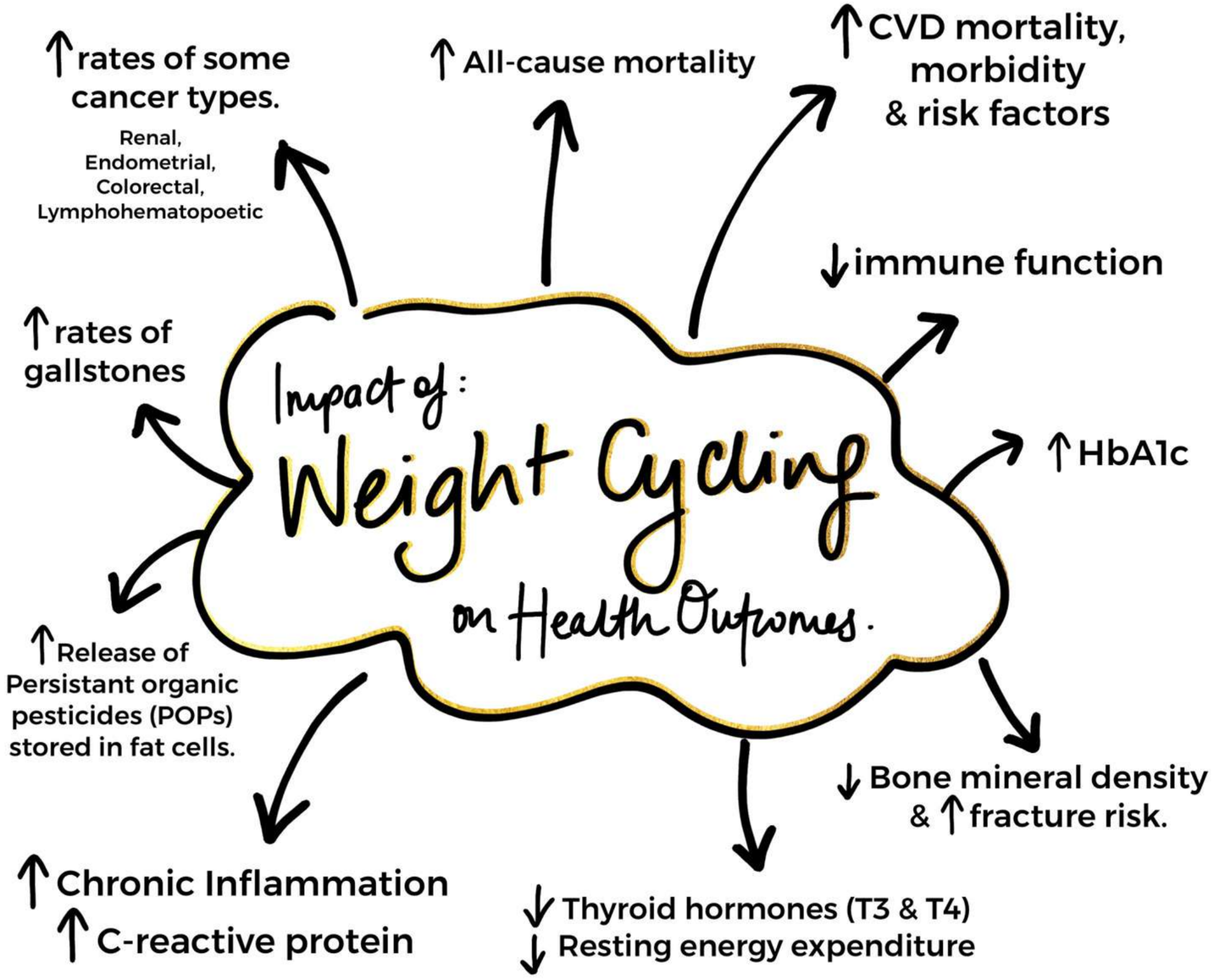
↑ Grehlin Associated with:

- food anticipatory behaviour
- foraging/hoarding behaviours
- stress-response dysregulated eating
- implicated in memory, learning & motivation
- associated with anxiety & mood via mesolimbin dopainergic circuitry.

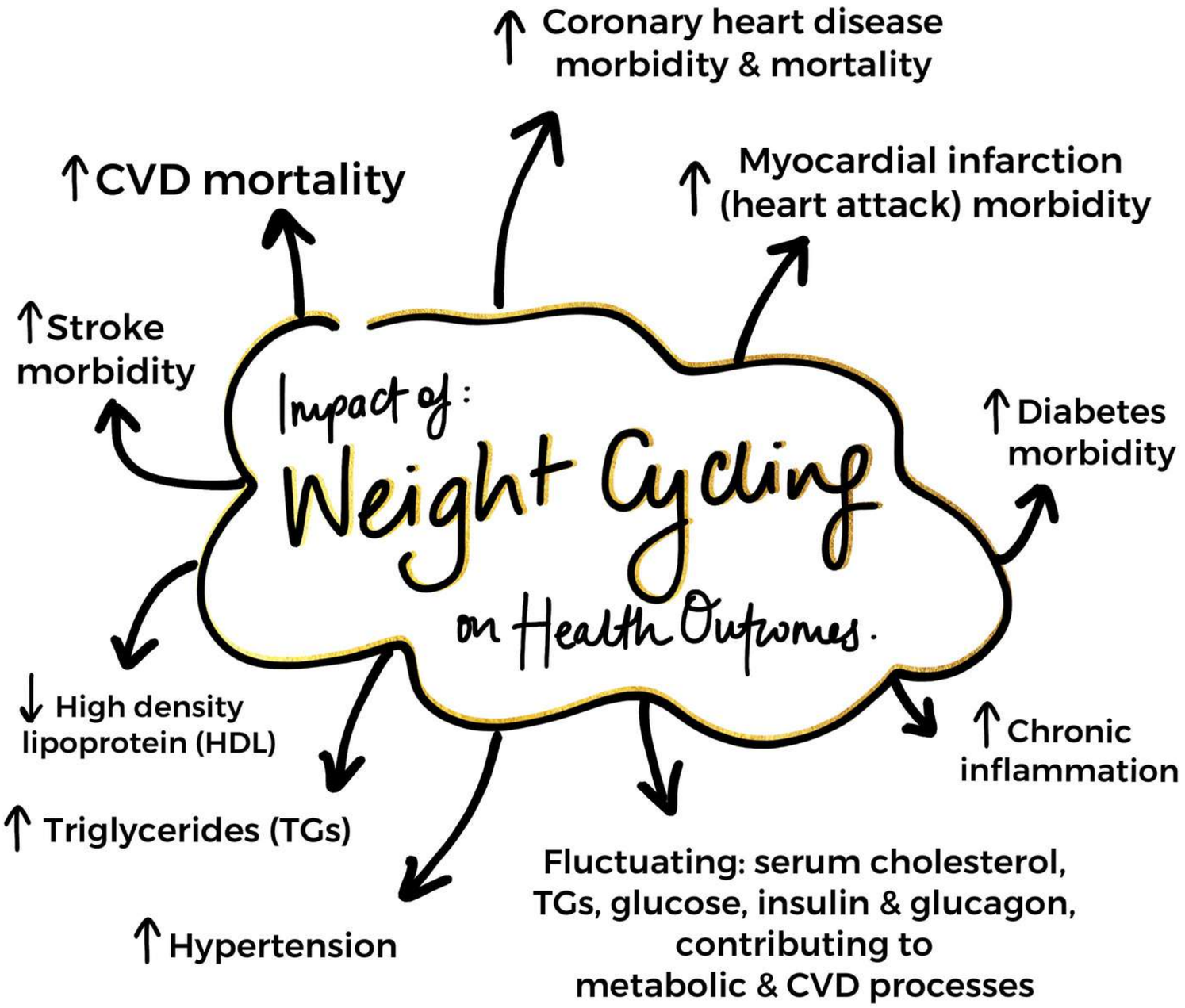
Assumption 5. Weight loss confers health improvement

- Lifestyle interventions often erroneously attribute health gains to weight loss.
- In a rigorous lab controlled study expanding 500 kcal per week the results were stratified by weight loss responders and non responders - interestingly the study found both groups improved systolic blood pressure and resting heart rate. We can infer that health gains are attainable independent of weight loss.
- On balance, the evidence that weight loss results in appreciable long-term improvements in health outcomes is weak.
- Meta-analyses of intervention studies for adults at risk for hypertension found that the amount of weight lost during the intervention was not reliably associated with improvements in blood pressure.
- We assume weight loss confers and risk reduction to that of having never been at a higher weight before (this is not data driven)

Overview


↑rates of some cancer types.
Renal, Endometrial, Colorectal, Lymphohematopoetic
↑All-cause mortality
↑CVD mortality, morbidity & risk factors
↓immune function
↑rates of gallstones
Impact of:
Weight Cycling
on Health Outcomes.
↑HbA1c
↑Release of Persistant organic pesticides (POPs) stored in fat cells.
↓Bone mineral density & ↑fracture risk.
↑Chronic Inflammation
↑C-reactive protein
↓Thyroid hormones (T3 & T4)
↓Resting energy expenditure

Cardiovascular



If not dieting, then what?

Appetite for change

2013 NHRMC, shared:

Table C27 (cont)

LONG-TERM WEIGHT MANAGEMENT					
How effective are lifestyle interventions in maintaining weight loss in adults?					
Weight loss following lifestyle intervention is maximal at 6–12 months. Regardless of the degree of initial weight loss, most weight is regained within a 2-year period and by 5 years the majority of people are at their pre-intervention body weight.					**A**
Evidence base A	***Consistency*** B	***Clinical impact*** A	***Generalisability*** A	***Applicability*** A	
REFERENCES: Dansinger et al. 2007; Schmitz et al. 2007; Stahre et al. 2007; Cussler et al. 2008; Martin et al. 2008; Svetkey et al. 2008; Cooper et al. 2010; Neve et al. 2010					
How effective are pharmacological interventions at maintaining weight loss in adults?					

Appetite for change

2018 RACP position statement on Obesity:

"Revise clinical guidelines for weight management of adults to incorporate:
o The **evidence on the low likelihood of long-term efficacy and potential detrimental effects for repeated attempts at weight loss**.
o An **emphasis on the importance of optimising health and managing treatable risk factors at any weight.**
o The need to ensure the physical environment meets the needs of people with obesity and **minimise the direct and indirect impacts of weight bias in the health system**."

2018 RACP position statement on Obesity:

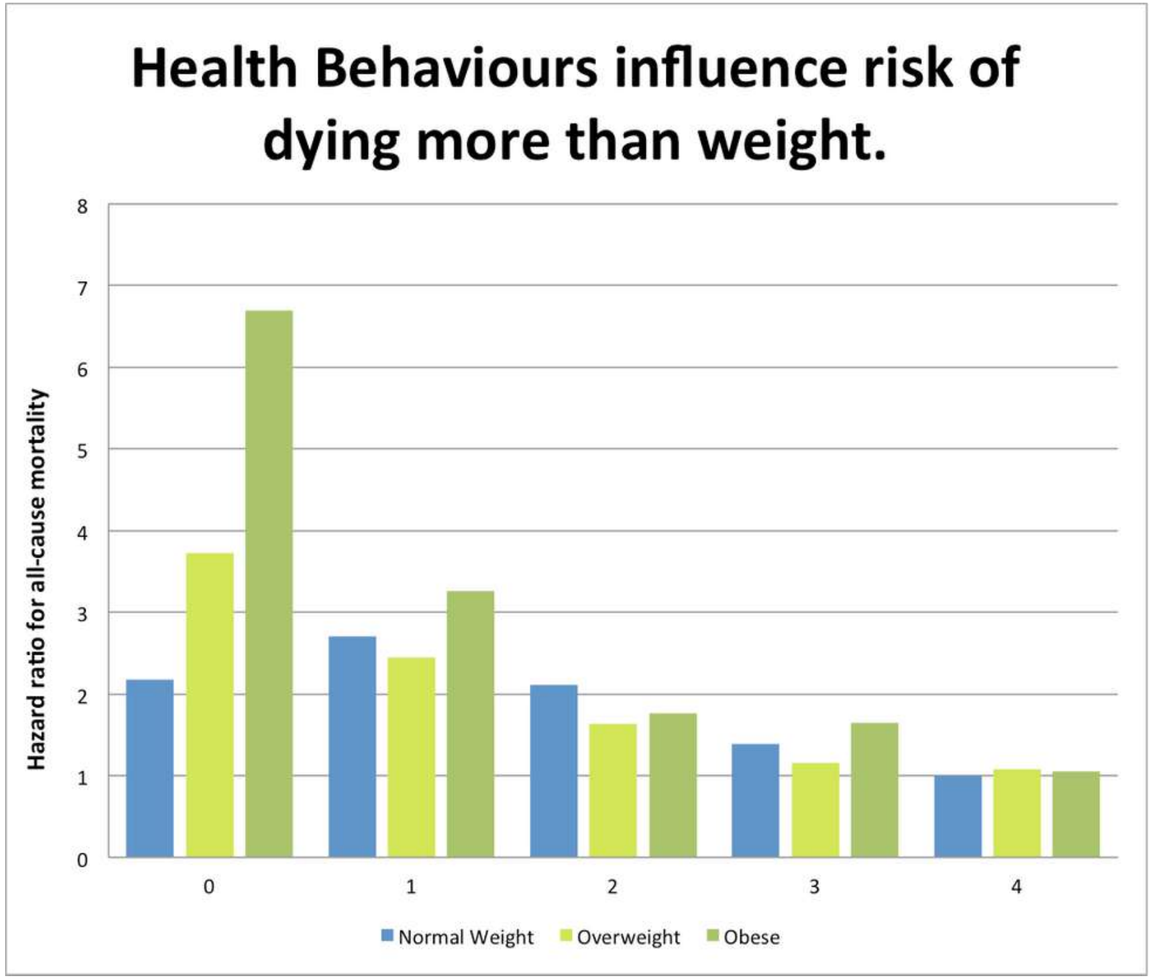
"Encourage RACP members to support individual and family/whānau to **optimise their health irrespective of weight** through improved nutrition and physical activity, and ensure patient education is specific, actionable and achievable"

Appetite for change

2019 RACGP **support move from weight loss to health gain**

"Weight bias and stigmatisation are serious issues affecting the health and wellbeing of people living with obesity. People with obesity may avoid healthcare if they feel shamed about their weight. Public obesity messages that focus only on weight and individual factors contribute to stigma and bias. The emphasis should shift from loss of weight to gain in heath."

Weight Inclusive Care – modify risk via behaviours not weight loss



Healthy habits:

- Consumption of 5 fruits or vege/day
- Regular exercise 12 times/month
- Moderate alcohol consumption (up to 1 drink/day for women, up to 2/day for men)
- Not smoking.

Matheson, E. M., King, D. E., & Everett, C. J. (2012). Healthy lifestyle habits and mortality in overweight and obese individuals. The Journal of the American Board of Family Medicine, 25(1), 9-15.

Weight Inclusive Care

- Alternative paradigm to weight centric care.
- Everybody is capable of achieving self -determined aspirations of health and well-being independent of weight, given access to non-stigmatising health care.
- Interventions don't seek intentional change or manipulation of body weight or shape.
- Accepting of size diversity, addresses stigma, discrimination & medical needs.
- Health At Every Size® is a practice philosophy, with 5 principles to facilitates the delivery of weight inclusive care.

Health at Every Size | HAES®

- Alternative paradigm to weight centric care.
- Everybody is capable of achieving self -determined aspirations of health and well-being independent of weight, given access to non-stigmatising health care.
- Interventions don't seek intentional change or manipulation of body weight or shape.
- Accepting of size diversity, addresses stigma, discrimination & medical needs.
- Health At Every Size® is a practice philosophy, with 5 principles to facilitates the delivery of weight inclusive care.

Comparison of Approaches

Component	Health at Every Size®	Intuitive Eating™	Generic weight neutral 'lifestyle'	Non-Diet Approach	Fat activism (originated in 1960's)
Social justice/activism – working to end size discrimination and oppression in broader community and systems	✓				✓
Does not aim to control or change body weight	✓	✓	May claim 'obesity prevention'	✓	✓
Nourishment (science-informed, self-directed)	✓	✓	✓	✓	
Physical activity (science-informed, self-directed)	✓	✓	✓	✓	
Internal autonomy via principles of self determination theory	✓	✓	Internal or external	✓	✓
Body image, body dissatisfaction, internalised weight bias, own size acceptance (*the individual*)	✓	✓	✓	✓	✓
Self Compassion building (resilience, positive self-regard)	✓			✓	
Counselling styles: Motivational Interviewing, ACT			MI/ACT/CBT	✓	
Informed by scientific research	✓	✓	✓	✓	Ethics/ justice/law/ philosophy

Health at Every Size | HAES®

Principle are determined by the Association for Size Diversity & Health (ASDAH):

1. Weight Inclusivity

2. Health Enhancement

3. Respectful Care

4. Eating for Well-being

5. Life-Enhancing Movement

1. Weight Inclusivity

Statement:

Accept and respect the inherent diversity of body shapes and sizes and reject the idealising or pathologising of specific weights.

Application:

- Recognise that there is no moral obligation for higher weight patients to lose weight ("perform health").
- Validate patient weight concerns.
- Reassure that weight does not equate to "health status" and health gain can be attained independent of weight loss.
- Encourage body acceptance & appreciation in self and others.
- If anthropometry is indicated in a clinical interaction - explain why, ask for consent & offer blind weights where requested. DO NOT weight or provide commentary in a public space.

2. Health Enhancement

Statement:

Support health policies that improve and equalise access to information and services, and personal practices that improve human well-being, including attention to individual physical, economic, social, spiritual, emotional, and other needs.

Application:

- Partner with patient access - screening, testing, diagnosis, medication, early intervention and higher level of care gated with BMI exclusion criteria.
- Run best medical management AND lifestyle management in parallel rather than hurdle medical care with weight loss trials.
- Speak with colleagues, friends and family about anti-fat attitudes and weight based discrimination.
- Be informed, remain curious and be critical of the evidence base.
- Engage in anti-racism work, recognise that weight centric medicine intersects with other forms of oppression - weight based health inequities disproportionately impact BIPOC
- Broaden your practice lens of "health" beyond physical outcomes, take a holistic, systems view.

3. Respectful Care

Statement:

Acknowledge our biases, and work to end weight discrimination, weight stigma, and weight bias.

Provide information and services from an understanding that socioeconomic status, race, gender, sexual orientation, age, and other identities impact weight stigma, and support environments that address these inequities.

Application:

- Be aware of and **engage in ongoing personal work to reduce thin bias and anti-fat bias.**
- Reflective practice, clinical supervision, online networking, reading widely, engage in therapy if concerned about own relationship with body.
- If you **make a mistake,** or recognise you've made an incorrect assumption about someone based on their body size or ability, **own it and apologise. Repair the relationship.**
- Ensure clinical spaces are welcoming for all bodies, **audit waiting rooms and clinic rooms** - chairs, benches, scales placed out of sight, what do the posters say? Magazines represent diverse range of bodies, equipment readily accessible - blood pressure cuffs, speculums, gowns - nothing says you're different or inconvenient like having to hunt around for size appropriate equipment.

4. Eating for Well-being

Statement:

Promote flexible, individualised eating based on hunger, satiety, nutritional needs, and pleasure, rather than any externally regulated eating plan focused on weight control.

Application:

- Connect and network with Non diet dietitians and nutrition professionals. Refer patients out for skilled care.
- Non-diet approaches, intuitive eating - eating for the purpose of nourishment not weight control, whilst recognising diet - health promotion / disease connection (MNT).
- Feeding lead by appetite.
- Process focussed not outcome focussed - self determined, experiential, centres "eating experiences" as learning opportunity and process to reconnect with innate ability to feed oneself.

Dietetic practice paradigms congruent with a HAES® practice philosophy.

5. Life-Enhancing Movement

Statement:

Support physical activities that allow people of all sizes, abilities, and interests to engage in enjoyable movement, to the degree that they choose.

Application:

- Connect and network with Non-diet & HAES informed Physiotherapists, personal trainers and exercise physiologists. Refer patients out for skilled care.
- Activity selection is important - decentre "no pain no gain" recentre enjoyable movement and connection with others.
- Recognise and communicate cardiorespiratory fitness as health promoting & weight bearing/loading activity as protective
- Process focussed not outcome focussed - self determined, experiential, centres "exercise experiences" as learning opportunities.
- Recognise and validate that weight stigma is a barrier to engaging in physical activity.

Practitioners are using this model of care.

Active networks of **5,000+ Nutrition Professionals across Australasia** interested in or currently working from a weight inclusive practice.

1,800+ Medical Professionals interested in non-diet practices.

Just this month - nephrologist in **CCDHB successfully advocated for the review of BMI in exclusion criteria in kidney transplant surgery** - interest at ADHB to continue the discussion.

ADHB urology department exploring **weight stigma and bias through inservice** trainings.