WEIGHT-CENTRIC VS. WEIGHT-INCLUSIVE HEALTHCARE

Comparative Chart

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Content Warning: includes anti-fat language

Utilize the table below to learn more about the Weight-Centric and Weight-Inclusive models of healthcare. This table is meant to be used as a guide to start conversations. We recognize that this is a nuanced topic that encompasses a spectrum, rather than two clear-cut categories. You may find you fall somewhere in between these two models of care.

Additionally, the Weight-Inclusive column may feel aspirational due to larger systemic issues. It is okay if what you've practiced in the past or present does not always reflect this approach. Our intention is not to call out, but to shed light on how personal beliefs about body weight and health impact patient care and outcomes, and how these beliefs can be shaped by medical training and healthcare systems.

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WEIGHT-CENTRIC VS. WEIGHT-INCLUSIVE HEALTHCARE

Comparative Chart

	A Weight-Centric View	A Weight-Inclusive View
Do patients control their weight?	Though control of weight is complex and multifactorial, patients can make choices that will lead to a long-term change in their body weight (e.g. diet, exercise, medication, surgery).	Weight naturally varies for many reasons and can respond unpredictably to behaviors that are health promoting. Long term weight suppression is not safe or sustainable for the overwhelming majority of patients. Factors at play in a person's body weight may include genetics, health conditions, medications, age, food access, and more.
Can a change in weight lead to reduction in risk of disease?	Changes in weight can directly decrease risk for disease, based on the assumption that achieving a normal BMI (18.5 - 24.9) is associated with a lower risk of developing disease. Any change towards a normal BMI is protective against the risk for disease, even if only in the short term.	For the majority of patients, efforts made to suppress weight often result in weight cycling (repeated loss and regain of weight), which is correlated to higher overall morbidity and mortality, regardless of BMI category. There is no disease that only exists in larger-bodied people - a variety of health statuses occur across the full spectrum of body weights.

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	A Weight-Centric View	A Weight-Inclusive View
What language do you use to describe bodies? *If you are curious about the language used in this document, please check out our language guidelines here.*	Uses terminology as defined by BMI categories ("obesity" "overweight" "normal/healthy weight" "underweight"). Often uses person-first language such as "a patient with obesity", which equates body size with a disease. Considers patients who have a BMI of 18.5-24.9 as being a "healthy" or "normal" weight. Attaches a moral value to the word "fat", believing it to be bad and undesirable.	Avoids using the terms "obese" and "overweight" because they pathologize higher body weight, classifying it as an illness. Acknowledges that using person-first language does not reduce weight stigma and refrains from that practice. Mimics what a patient uses for themselves, including using "larger body" "thin" or "fat" as neutral descriptors. If needing to communicate body size for a very specific purpose (surgical planning, CT/MRI scans), uses weight and height alone, or descriptors such as "larger body" for communication, only if relevant.
What is your procedure for weighing patients?	Patients are weighed at every visit. Weight is routinely disclosed to patients.	Believes that taking weight is a medical intervention in and of itself. Only weighs patients when it is directly relevant to their medical care (such as medication dosing). Recognizes that taking weight could be psychologically harmful to patients. As a result, asks for permission before taking weight, and gives patients a choice prior to disclosing weight.

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	A Weight-Centric View	A Weight-Inclusive View
How do you frame the discussion if a patient inquires about weight loss or weight loss medication?	Generally supports weight loss in most patients, unless they are "underweight" by BMI. Perceives this support as a reflection of their investment in improving patients' health and well being. Provides skewed informed consent - overstating benefits and understating risks.	Fosters discussion to learn more about patients' goals and motivations. Recognizes there are many ways to meet any health goal. Provides informed consent about the perceived benefits as well as the risks of weight loss, dieting, or medication.
How is weight considered while developing your treatment plan?	Patients are generally counseled on their weight if they fall above the normal BMI category at every visit, regardless of the chief complaint. Promotes weight loss as a primary strategy in the treatment and prevention of various medical conditions. May recommend a trial of weight loss, or "lifestyle modifications" aimed at weight loss, prior to other evidence-based treatments.	Approaches treatment recommendations in the same manner, independent of a patient's BMI classification. Centers treatment around the patient's chief complaint. Does not typically mention weight, and asks patient for permission prior to mentioning weight, if it is medically necessary. Additionally, acknowledges that there are many methods of health optimization that are beneficial long-term and don't focus on weight loss such as improving sleep, managing stress, regular movement, and (if possible in a person's context) eating regular nourishing meals.

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	A Weight-Centric View	A Weight-Inclusive View
Where do you seek information about the relationship between body size and health?	Prioritizes information shared by experts and traditional sources of information including keeping up with the latest research on obesity, body size, and health.	Utilizes traditional sources of information while thinking critically about the effects of bias in these sources. For example, seeing when data from a primary source doesn't always support the conclusion presented, when critically analyzed. Prioritizes information and experiences shared by the individual patient and the size-inclusive community.

Resources to learn more:

- Newsletter: Weight and Healthcare Substack by Ragen Chastain
- Books:
  - Anti-Diet by Christy Harrison
  - Belly of the Beast: The Politics of Anti-Fatness and Anti-Blackness by Da'Shaun L. Harrison
  - Fat Talk: Parenting in the Age of Diet Culture by Virginia Sole-Smith
  - Fearing the Black Body by Sabrina Strings
  - What We Don't Talk About When We Talk About Fat by Aubrey Gordon

- Podcast: The Maintenance Phase hosted by Aubrey Gordon and Micheal Hobbes
- NAAFA Guidelines for Healthcare Providers:
- Research articles: https://weightandhealthcare.substack.com/p/the-research-post

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BRIEF TIPS TO BE A MORE WEIGHT-INCLUSIVE PROVIDER

The actions below are examples of ways to practice more weight-inclusive care. This list is not exhaustive. These tips are aspirational and meant to give ideas of what fully weight-inclusive care would look like. We recognize that our ability to implement some of these steps may be limited by the weight-centric structures in which we work.

Language:

- Mimic the terminology a patient uses to describe themselves
- Avoid the terms “obesity” “overweight” “healthy weight” “underweight”
- Avoid person-first language e.g. “person with obesity”
- Use terms like “larger-bodied”, “higher weight”, “thin”, “fat” as neutral descriptors
- Resource: “Should you use the word fat?” by Lindley Ashline

Weighing patients:

- Do not weigh patients unless it is directly relevant to care
- Ensure taking weight is not the first experience a patient has in your office and always ask permission beforehand
- Blind the patient to their weight if requested
- Do not verbalize the weight unless asked
- Place the scale in a private area
- Ensure your scale can weigh an entire spectrum of patients
- If weight is charted, inform patient that it may appear on their patient portal and other communications

Clinical practice considerations:

- Avoid using BMI. Prioritize lab values and other measures of patient health
- Avoid praising weight loss
- Consider how you would treat a thin patient with the same chief complaint
- Make sure your office has equipment suitable for patients of all sizes
- If unable to accommodate a patient, make effort to know where to refer them
- Ensure any depictions of patients in your office represent patients of all sizes
- Eliminate mention of weight during patient visit unless strictly necessary
- MSSI RESOURCE: “What if a patient wants to discuss weight loss?”

Assess and challenge your weight bias:

- Take an Implicit Association Test
- Notice and interrupt negative stereotyping or actions
- Connect with people in larger bodies – listen to their experiences and create a personal connection
- Practice empathy and compassion towards people regardless of body size

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