

WEIGHT INCLUSIVE

HEALTHCARE

INITIATIVE



INTRODUCTION

Our perspectives are informed by our wide range of racial and socioeconomic backgrounds. Although we may have experienced weight bias and/or eating disorders, which drew us to this work, many of us who created this guide benefit from thin privilege and are not members of the fat community. We acknowledge that we navigate life without additional barriers due to our weight. We also acknowledge that our perspectives are partially informed by the roles we play in the healthcare and health sciences spaces, which have historically perpetuated harm. Our lens around this work comes from a combination of personal experiences and gaps in perspective due to our privileges.

Our goal with this guide is to center those who have been dismissed in the healthcare system due to their weight and to center those who have been historically marginalized in medicine. We know that countless times both racial and weight bias in the healthcare system deters patients from wanting to enter the doctor's office. We desire for this to be an easy and simple guide that patients, students, healthcare professionals and the general public can use within their daily lives and the healthcare setting.

Medicine often focuses on viewing people as numbers and science experiments that need to be fixed rather than viewing people more holistically—whether it be their environment or viewing health from a more broad lens. Therefore, this guide is our offering to making healthcare a more just and healing place for those in larger bodies and historically marginalized people.

Overall, we challenge healthcare's dehumanizing narrative by focusing less on weight and re-imagining health to center wellness, joy, and fueling our bodies, while acknowledging the structural barriers at play. Instead of viewing patients in larger bodies as problems that need to be fixed, we hope that this guide provides the historical context, as well as educational tools, to better serve and love patients in larger bodies.

STUDENT AUTHORS

Divya R. Alley
Divya Vemulapalli
Annika Ballantyne
Laurel M P Neufeld
Sophia Harris
Varsha Venkat (MD)
Lenora Goodman (RDN)
Ayomide Ojebuoboh (CPT)

REVIEWERS

Dr. Whitney Trotter (MS, RDN/LDN, RN, RYT)
Dr. Andrea Westby (MD)
Carolina Guizar (MS, RDN, CDN)
Association for Size Diversity And Health

GRAPHIC DESIGNER

Sydney Lo

*Thank you to the Institute for Healing & Justice In Medicine
for housing our work*

DISCLAIMERS

Talking about weight can be a sensitive topic. We wanted to note that some of these topics may be triggering, as we discuss fatphobia, anti-Black racism, eating disorders/disordered eating, and how these topics are intertwined with trauma.

Throughout the text, we use the word “obesity” to reflect how body size has been pathologized in medicine and science.

TABLE OF CONTENTS

RACISM & EUGENICS OF BMI	5
THE PATHOLOGIZATION OF SIZE	22
WEIGHT STIGMA IN HEALTHCARE	36
NAVIGATING NUTRITION AND DISORDERED EATING IN A DIET CULTURE ERA	49
JOYFUL MOVEMENT	73

CHAPTER 1

PART 1:

RACISM & EUGENICS OF BMI



From the moment white europeans saw fat Africans, the science that followed was intended to always separate them from the rest. In this way, the BMI - created to maintain whiteness “as superior was always going to harm the Black fat and it is for this reason that Black people make up over half of the fat population and why Black people also have more “health risk” than their white counterparts”

– Belly of the Beast by Shaun L. Harrison

ANTI-FATNESS AND ANTI- BLACKNESS

1400-1600S: RENAISSANCE EUROPE

During this era, fatness was celebrated. The Irish famine which lasted during 1845-1852 left many people with a lack of food and therefore, led society to equate those who were able to eat in excess with wealthiness.¹⁹ Those who were wealthy including physicians, lawyers and bankers were viewed as attractive if they were in larger bodies.⁴ This same glorification of fatness was presented in art pieces created during this time period like Mona Lisa which was painted in 1503 and presents a woman with broad shoulders, thick neck and a round face.²⁰

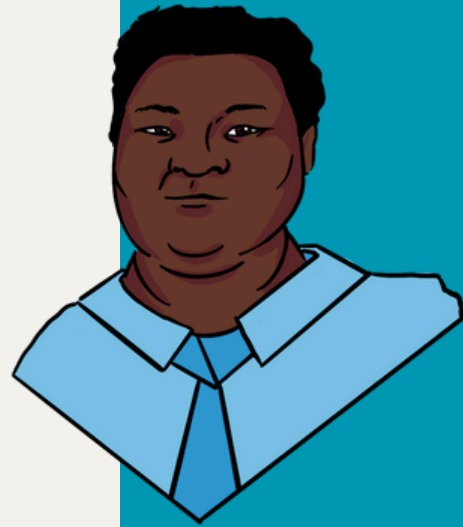
Women in large bodies represented fertility and men in larger bodies were viewed as powerful, while thinness in youth was viewed as undesirable and associated with morbidity and a lack of will.^{4,19} All in all, fatness was equated to wealth while art and fashion celebrated voluptuous bodies and the implication of life without labor.



1600-1800S: TRANSATLANTIC SLAVE TRADE AND RACE SCIENCE

During the slave trade in the 18th century, there was a higher desire to differentiate between who was considered “enslaved” versus “free” so there began to be a focus on eating body size.²¹ At this point, women were praised for being in larger bodies but French philosophers began to notice that Africans in the colonies loved food and were also fat.⁷ Black women were also viewed as “savage” aesthetic inclinations and consuming amoral appetites.²² So Europeans began to feel a greater pressure to be thinner and not eat as much in order to distinguish themselves from those who were Black and enslaved.⁷

This anti-fat bias rhetoric also began to promote racial scientific literature from the 18th century that spread the message that fatness equals “savage” and “Black”.⁸ The Protestant perspective of moralism and disdain for indulgence promoted pro-thin, anti fat bias but there that was a racial component to fat-phobia.⁸ When scientists began documenting differences between races, size became associated with mental and moral failings and gender differences were associated with interpretations of fatness like the fetishization of Black women and demeaning Black men.






1800-1900S: AMERICAN EXCEPTIONALISM & CODIFYING BEAUTY STANDARDS

Within the scientific literature, there continued to be a focus on demeaning Black peoples' bodies, but even more specific, Black women. While Black people were viewed as "uncivilized," Black women were viewed as "lacking in normal restraint" and "given to excess".²³ For example, a colonial British army officer named John Hanning Speke wrote during his expeditions between 1844-1864: "To please men, African women eat enormous quantities of bananas and drink milk by the gallon...one of the much-admired dusky wonder of obesity, who was unable to stand except on all fours".⁹ The association between primitiveness to black femininity and fatness re-emerged by displaying Black women as ways of being out of control.

Race scientists simultaneously began to adopt the ideology of Christian physiologists which were concerned about overfeeding and focused on the association between abundant eating and fitness.²⁴ Eventually, mass media also began to publish scientific articles to differentiate between white "civilized" bodies and Black "savage" bodies including a religious focus on Christian eating and lean physiques. Then during the late 19th century, medical practitioners viewed Black women as destined to die with Black men because they were unable to control their "animal appetites" of eating, drinking, and fornicating.²⁵



1900S-PRESENT DAY: MEDICALIZATION OF FATNESS AND DEMOGRAPHIC BLAME

In 1997, the World Health Organization (WHO) officially announced that “obesity” was a major public problem and global epidemic.²⁶ “Obesity” was then officially medicalized as a disease in 2013 by the American Medical Association in hopes that “obesity” would be viewed as more than physical corpulence and/or moral failing.²⁷ However, this fails to acknowledge the racialization of “obesity” which, according to Oni and Winant, is defined as “any representation of race [that] invokes essentialized racial categories in a way that (re)produces racial inequality.”²⁸ Black women began to be the face of the “obesity epidemic” through building on the concept of the welfare queen.

This image paints Black women as lazy individuals who acquire unearned income through exploiting the welfare system. This unemployment status demonstrates her moral deviance and excess within her body and lifestyle.¹⁵ Overall, this was a time period where the moralization of thinness was perpetuated, “obesity” became codified into medical legitimacy, and fatness became a way to blame Black communities and individuals for adverse health outcomes.

CHAPTER 1

PART 2: BMI DISCUSSION



“

LIKE PHRENOLOGY AND POSITIVIST CRIMINOLOGY BEFORE IT, THE BODY MASS INDEX IS A PRODUCT OF ITS SOCIAL CONTEXT. AND, EVEN ACCORDING TO ITS BIGGEST CHAMPIONS, IT'S NOT AN EFFECTIVE MEASURE OF FATNESS, MUCH LESS OVERALL HEALTH.

”

— AUBREY GORDON, AUTHOR OF *WHAT WE DON'T TALK ABOUT WHEN WE TALK ABOUT FAT AND YOU JUST NEED TO LOSE WEIGHT* AND CO-HOST OF “MAINTENANCE PHASE” PODCAST

ORIGINS OF BMI

The 19th Century

The origins of the Body Mass Index can be traced to Adolphe Quetelet, a mid-19th century Belgian mathematician, astronomer, and statistician who, in fact, was neither concerned with “obesity” nor the study of medicine. Rather, Quetelet was interested in identifying the mathematical mean of a population – *l’homme moyen* or the ‘average man’— whom he believed represented the ideal.¹ In 1832, Quetelet proposed that normal body weight in kilograms was proportional to the square of the height in meters for adults; this was later termed “**Quetelet’s Index**” by some.

It is important to note that Quetelet formulated his index based entirely on the weights and measurements of French and Scottish participants.² Furthermore, Quetelet intended for this index to be utilized only at the population-level, not as a measure of individual body fat or health, for that matter.³ Quetelet’s Index, however, would be lost to history for several more decades.

Early 20th Century

Weight emerged as a primary indicator of health in the early 20th century when life insurance companies in the United States noticed that policyholders with the highest weight-to-height ratios were more likely to die early compared to those with average weight-to-height ratios.⁴

As a result, insurance companies relied on “medico-actuarial standards of weight and health”, or weight-to-height tables, in order to determine what to charge new policyholders based on their mortality risk. Notably, the data that informed these tables were obtained from those with the means and resources to purchase life insurance: “working-age, middle-class white men”.⁴ In 1912, Louis Israel Dublin, an American statistician working for the Metropolitan Life Insurance Company, developed a new Standard Table of Heights and Weights based on data from hundreds and thousands of life insurance policyholders.

The **Metropolitan Life tables** became widely known, mentioned and printed in various media. However, once again, the data were not representative of the greater population: there was a clear lack of women as well as racial and ethnic minority participants.⁴ Dublin revised these tables in 1937 to include body frame (small, medium, and large) as another metric alongside weight and height, though it is unclear how “body frame” was measured. In 1959, the Metropolitan Life tables received another update, this time delineating “desirable weights” for each body frame type.

Despite a lack of medical expertise involved in the design of the actuarial tables and their overall flawed methodology, these tables were regularly consulted by physicians in assessing their patients’ “ideal weight” and health.⁴

Late 20th Century

During the 1960s, after World War II, there were more concerns regarding the relationship between weight and mortality, particularly with regard to conditions such as diabetes and cardiac disease. This led to a growing need for a standardized index of relative weight to be used in scientific and clinical research. Ancel Keys, an American physiologist who is best known for his studies of diet and nutrition, found the 1912-1959 Metropolitan Life tables to be highly inadequate. Through his search for a more effective measure of weight, Quetelet's Index was rediscovered.

In 1972, Keys developed a comparative study along with several other researchers to identify the most effective measure of body weight and fat. The study was called "Indices of Relative Weight and Obesity" and was published in the *Journal of Chronic Disease*. Keys and his fellow researchers compared various indices of relative body weight, including Quetelet's Index, with 7,500 male subjects from the United States, Finland, Italy, Japan, and South Africa.

Keys determined Quetelet's Index to be the strongest of the tested measures and renamed it the "**Body Mass Index**", the term we use today. Despite making a case for the validity of the BMI, Keys wrote ambiguously about its efficacy: "Again the body mass index... proves to be, if not fully satisfactory, at least as good as any other relative weight index as an indicator of relative obesity".³ As with Quetelet's Index and the Metropolitan Life tables, the findings of this study conducted by Keys and colleagues are primarily derived from white, Western European populations. In other words, the BMI is inherently flawed with regard to its generalizability to other populations.

Table 1. World Health Organization, BMI Categories (1995)

Category	BMI Cutoff Points
Overweight	≥ 25
Pre-obesity	25.0 - 29.9
Class I Obesity	30.0 - 34.9
Class II Obesity	35.0 - 39.9
Class III Obesity	≥ 40.0


Although Keys and his coauthors acknowledged that Quetelet designed his measure to be used for population studies, not individual health, the newly coined BMI became cemented in the world of individual healthcare. In 1985, the **National Institutes of Health (NIH)**, updated its definition of “obesity” to be contingent upon individual patients’ BMI, among other factors.⁵ As a result, BMI was formally codified into US health policy.

The Turn of the 21st Century

Similar efforts were also occurring at the international level. In 1995, the **World Health Organization’s (WHO) Expert Committee on Physical Status** published a report that proposed BMI cutoff points of 25, 30, and 40 to represent three degrees of overweight. The authors also noted that these BMI classifications were designated based on an “arbitrary method of association between BMI and mortality”.⁶

This was an apt statement given that between 1985 and 1995 the goalposts for BMI categories kept changing. In 1985, the NIH classified “overweight-obesity” as a BMI of ≥ 27.8 for men and ≥ 27.3 for women. Meanwhile, in 1990, the US Department of Agriculture proposed one standard for both men and women that would be dependent only on age: “unhealthy” weight would mean a BMI ≥ 25 for those under thirty-five and a BMI ≥ 27 for those over thirty-five.

The WHO published another report in 1995 called the **Dietary Guidelines for Americans** which established the “obesity” categories that are widely used today (Table 1). Importantly, critics have noted that the International Obesity Task Force, which was involved in the drafting of the WHO guidelines, received funds from Roche and Abbott, two companies that developed weight loss drugs.^{7,8}



In 1998, the NIH officially adopted the WHO's new guidelines, effectively lowering its previous cutoff for "overweight-obese" from 27.8 to 25. As a result, 25 to 29 million American adults who were previously considered to be of "normal weight" were labeled overweight, and therefore at risk for various health conditions, overnight.⁹ The *New York Times* headline marking this change read, "U.S. to Widen Its Definition of Who Is Fat".⁴ Similarly, a CNN article remarked, "Millions of Americans became 'fat' Wednesday — even if they didn't gain a pound — as the federal government adopted a controversial method for determining who is considered overweight".¹⁰

This change was indeed controversial. Eric Oliver, author of *Fat Politics: The Real Story Behind America's Obesity Epidemic*, reported that Xavier Pi-Sunyer, Columbia University professor of medicine and the then chairman of the NIH committee that voted to adopt the WHO guidelines, had several concerning conflicts of interests. Pi-Sunyer was a paid consultant for various weight loss drug companies and was also on the Board of Directors of the Weight Watchers Foundation.^{8,11}

WHAT ARE SOME OF THE FAILINGS OF BMI?

Although body mass index (BMI) has been used for generations in the healthcare system to make predictions on patients' weight and their health, there has been critical analysis of the failings of such a measure on individual health and the healthcare system. BMI is a simple tool that is based on a person's height and weight and suggests it can estimate the body fat of individuals. However, factors such as age and sex can influence the relationship between BMI and body fat which are unaccounted for in current BMI calculations. Additionally, there are fundamental differences in a person's bone mass, muscle mass, and excess fat, but BMI does not distinguish between these different types of body weight,¹² proving it to be an inaccurate measure.

Alongside these clinical limitations, BMI's exclusive focus on body fat to estimate the future health risks of individuals leads it to exclude the impacts of other important factors. A primary example of this is the social determinants of health, which includes factors such as socioeconomic status, access to nutrient-rich foods, and discrimination in and out of the healthcare system. For example, when considering type 2 diabetes—a chronic disease that is oftentimes associated with weight—there is growing evidence that discrimination and poverty are more strongly linked with the condition than conventionally-accepted factors, including body weight.^{13,14}

Additionally, evidence on the impacts of chronic stress on health due to colonization is coming to light. For example, consider the Bengal famine of 1943 which was created by British rulers when they continuously exported rice out of the country during wartime. Research has shown that descendants of survivors of this famine are at increased risk of type II diabetes. It is thought this is due to epigenetic effects that impact the predisposition to cardiometabolic diseases in South Asians.¹⁵ Similarities are seen with the 1954 Chinese famine and increased risk of diabetes in fetuses exposed to conditions of starvation.¹⁶ These studies showed that being historically subjected to war, sexual exploitation, and inequity put severe stress on survivors' bodies, impacting their health as well as their descendants. Collectively, this demonstrates that BMI has failed to consider a more nuanced picture of what impacts human health, and it instead inaccurately tries to draw a two-dimensional line between body weight and health.

One of the most significant failings of the BMI system is that it has perpetuated a weight-centered approach to healthcare where patients are taught to focus on reaching a certain weight to be considered “healthy”. However, the reality is far from this assumption.

Although a weight-centered approach can result in short-term weight loss, most individuals are unable to maintain this in the long run and do not notice improvements in their chronic diseases that are “supposed” to improve with weight loss (e.g. high blood pressure, diabetes, etc).¹³ Additionally, several observational studies showed that weight loss in larger-bodied individuals puts them at an increased risk of premature death, including when the studies controlled for confounding factors such as underlying disease and risky behavior.¹⁷ Not only has BMI emphasized pushing for smaller, “healthier” bodies, but it has also had many unintended consequences including promoting weight cycling, fixation over food intake and body image, lower self-esteem, and increased misdiagnoses due to healthcare providers attributing chronic diseases to weight rather than considering other important factors that may be at play.¹³ Thus, targeting body weight through use of the BMI scale is both an inefficient and harmful public health intervention, and we must rethink using such a system that has perpetuated significant harm.

WHAT DOES A WEIGHT-INCLUSIVE FRAMEWORK IN HEALTHCARE MEAN?

Weight-inclusive care can take on many different forms and corresponding approaches. Here, we define weight-inclusive care to mean that people of all shapes and sizes have the right to compassionate and comprehensive healthcare that does not depend on meeting a specific BMI range or number on the scale.

A true weight-inclusive framework contemplates how our current understanding of health is rooted in anti-Blackness, white supremacy, and ableism; it pushes us to reflect on how we define health and illness. Weight-inclusive care creates a space for fat communities and individuals to share their experiences in healthcare and involves providers who are willing to listen without judgment, decentralize weight from health, and hold themselves accountable for fatphobia that is deeply embedded within their medical education and our healthcare system.

We hope that the rest of this guide reflects on the history of these harms and provides a framework for what weight-inclusive care can look like in practice.

Key Takeaways:

- **Origins & Formal Adoption of BMI:** Since the 19th century, there have been numerous attempts to define body size, leading to the creation of biased measures that primarily reflected white male data. Among these measures, BMI prevailed despite its acknowledged limitations. Over the years, the goalposts or cutoffs for BMI have shifted, with different definitions put forward by the NIH, USDA, and WHO, highlighting the arbitrary nature of the measure.
- **Weight-inclusive Care:** Such care can take on many forms with key components of providing compassionate and comprehensive healthcare that does not center on shape or size. A framework that truly highlights weight inclusivity must reckon with the anti-Blackness, white supremacy, ableism and other forms of discrimination rooted in the healthcare system.

SOURCES

1. Garabed Eknoyan, Adolphe Quetelet (1796–1874)—the average man and indices of obesity, *Nephrology Dialysis Transplantation*, Volume 23, Issue 1, January 2008, Pages 47–51, <https://doi.org/10.1093/ndt/gfm517>
2. Kubergovic, E. (2013, September 14). Quetelet, Adolphe. Retrieved January 31, 2023, from <http://eugenicsarchive.ca/discover/connections/5233cb0f5c2ec5000000>
3. Ancel Keys, Flaminio Fidanza, Martti J Karvonen, Noburu Kimura, Henry L Taylor, Indices of relative weight and obesity, *International Journal of Epidemiology*, Volume 43, Issue 3, June 2014, Pages 655–665, <https://doi.org/10.1093/ije/dyu058>
4. Strings S. (2019). *Fearing the black body : the racial origins of fat phobia*. New York University Press. Retrieved February 1, 2023 from <http://www.degruyter.com/isbn/9781479891788>.
5. National Institutes of Health. (1985, February). The National Institutes of Health Consensus Development Program: Health implications of obesity. Health Implications of Obesity: Consensus Development Conference Statement. Retrieved January 31, 2023, from <https://consensus.nih.gov/1985/1985Obesity049html.htm>
6. WHO. Physical status: the use and interpretation of anthropometry. Report of a WHO expert committee. Technical report series no. 854. Geneva: World Health Organization; 1995 from http://whqlibdoc.who.int/trs/WHO_TRS_854.pdf
7. Moynihan R. Obesity task force linked to WHO takes “millions” from drug firms *BMJ* 2006; 332 :1412 doi:10.1136/bmj.332.7555.1412-a
8. Butler, K. (2014, August 25). Why BMI is a big fat scam. *Mother Jones*. Retrieved February 1, 2023, from <https://www.motherjones.com/politics/2014/08/why-bmi-big-fat-scam/>
9. Squires, S. (1998, June 4). About Your BMI (Body Mass Index): Optimal Weight Threshold Lowered . *The Washington Post*. Retrieved February 1, 2023, from <https://www.washingtonpost.com/wp-srv/style/guideposts/fitness/optimal.htm>
10. Cohen, E. & McDermott, A. (1998, June 17). Who's fat? New definition adopted. *CNN*. Retrieved February 1, 2023, from <http://www.cnn.com/HEALTH/9806/17/weight.guidelines/>
11. J. Eric Oliver, *Fat Politics: The Real Story Behind America's Obesity Epidemic*, New York, Oxford University Press, 2006, p. 30.
12. CDC. BMI Frequently Asked Questions. BMI. July 2, 2024. Accessed November 12, 2024. <https://www.cdc.gov/bmi/faq/index.html>

13. Bacon L, Aphramor L. Weight Science: Evaluating the Evidence for a Paradigm Shift. *Nutr J.* 2011;10(1):9. doi:10.1186/1475-2891-10-9
14. Wamala SP, Lynch J, Horsten M, Mittleman MA, Schenck-Gustafsson K, Orth-Gomér K. Education and the metabolic syndrome in women. *Diabetes Care.* 1999;22(12):1999-2003. doi:10.2337/diacare.22.12.1999
15. The Susceptibility of South Asians to Cardiometabolic Disease as a Result of Starvation Adaptation Exacerbated During the Colonial Famines. *Endocrinol Diabetes Metab J.* 2022;6(2). doi:10.31038/EDMJ.2022621
16. Li Y, He Y, Qi L, et al. Exposure to the Chinese famine in early life and the risk of hyperglycemia and type 2 diabetes in adulthood. *Diabetes.* 2010;59(10):2400-2406. doi:10.2337/db10-0385
17. Williamson DF, Pamuk E, Thun M, Flanders D, Byers T, Heath C. Prospective study of intentional weight loss and mortality in never-smoking overweight US white women aged 40-64 years. *Am J Epidemiol.* 1995;141(12):1128-1141. doi:10.1093/oxfordjournals.aje.a117386
18. The Health at Every Size® (HAES®) Principles. ASDAH. Accessed November 12, 2024. <https://asdah.org/haes/>
19. Sermo. “The History of Obesity – the Renaissance to 1910.” Sermo, 25 June 2022, www.sermo.com/blog/insights/history-obesity-renaissance-1910/.
20. “The World Used to Love Fat Women - Fat Women in Ancient History.” Symptoms of Living, symptomsofliving.com/blog/the-world-used-to-love-fat-women/. Accessed 12 Nov. 2024.
21. “Fat Phobia and Its Racist Past and Present.” NPR, NPR, 21 July 2020, www.npr.org/transcripts/893006538.
22. Strings, Sabrina. “Fearing the Black Body.” NYU Press, 2 July 2019, nyupress.org/9781479886753/fearing-the-black-body/.
23. Strings, Sabrina A. *Thin, white, and saved: fat stigma and the fear of the big black body.* Diss. UC San Diego, 2012. https://escholarship.org/content/qt55p6h2xt/qt55p6h2xt_noSplash_e5667586b9c25b834761f58d1f7032ff.pdf
24. Sanders, R. (2017). The color of fat: racializing obesity, recuperating whiteness, and reproducing injustice. *Politics, Groups, and Identities*, 7(2), 287–304. <https://doi-org.ezp2.lib.umn.edu/10.1080/21565503.2017.1354039>

CHAPTER 2: **THE PATHOLOGIZATION OF SIZE**



THE OBESITY EPIDEMIC : HOW OBESITY CAME TO BE A DISEASE

The so-called “obesity epidemic” is a well-known entity in the public health sphere. Born out of moral panic over the claim that increased weight is associated with worse health outcomes, “rising rates of obesity” in the United States were promptly escalated to that of a “public health crisis.” In reality, body size diversity has existed across history¹ and was only more recently labeled as a disease. Although there are many facets that comprise one’s body shape and size, including height and foot size, weight was ultimately targeted as a modifiable entity indicative of one’s morality. Over time, the creation of size as a disease became a lucrative opportunity for those with vested financial interests to sell interventions for the “illness” of increased body weight.

From a social justice standpoint, the “obesity epidemic” has justified body size discrimination, compounding the harm already experienced by those who hold multiple marginalized identities. In this section, we will discuss the insidious history that led to the pathologization of body size. We will explore how the “obesity epidemic” was crafted, financed, and fueled by the wellness/diet industry. Finally, we will examine how pre-existing fatphobic beliefs informed the studies and treatments targeting “obesity” as a disease.

For most of human history, until the end of the 19th century, larger bodies were deemed healthier by doctors.² Thin, frail bodies, on the other hand, were a sign of poor health and antithetical to the ideal beauty aesthetics of the time.¹

In her book *Fearing the Black Body*, Sabrina Strings explores the racist, sexist, and classist origins of fatphobia. Strings' historical narrative highlights the evolving beauty standards of the time, which ultimately led to the birth of the thin, svelte aesthetic embodied by elite white women. Fat black bodies, on the other hand, were a sign of "savagery" and racial inferiority.¹

Thus, long before the medicalization of body size, larger bodies (specifically fat black bodies) were deemed immoral and undesirable from a cultural and beauty standpoint. **That is to say, fatphobic beliefs rooted in racism predated the creation of size as a disease in the medical field.**

Christy Harrison's book, *Anti-Diet*, explores the roots of diet culture and how the diet/wellness industry heavily influenced the crafting of the "obesity epidemic." **The following pages include a historical timeline (informed by Harrison's work) outlining key events that led to the publicization of the "obesity epidemic" as we know it today.**

“The Obesity Epidemic”

TIMELINE OF KEY EVENTS

1830

TRACKING BODY WEIGHT

Presbyterian minister and renowned speaker Sylvester Graham began promoting the idea that eating the “wrong” foods leads to health problems. In accordance with the Protestant times, Graham preached that “gluttony, and not starvation, is the greatest of all causes of evil.” Graham encouraged restrictive eating by labeling certain foods as “wholesome” and condemning others as causative of disease.

Although Graham’s diet was not intended for weight loss purposes, Graham and his followers began tracking their weights in order to disprove the notion that Graham’s diet resulted in starvation. These records serve as the **first evidence of Americans tracking their body weight.**³

1864

WILLIAM BANTING OF GREAT BRITAIN PUBLISHES “LETTER ON CORPULENCE: ADDRESSED TO THE PUBLIC”

As a victim of weight-related stigma, Banting was troubled by his weight and enlisted the help of his physician. Banting’s pamphlet outlines the experimental diet prescribed to Banting by his physician and details his weight loss journey over time.

This pamphlet was eventually published as the first ever self-help diet book.⁴ Banting’s work also brought scales into the public sphere, as people became obsessed with tracking their own weight.

1885

PENNY SCALE

The coin-operated “penny scale” was invented, offering an affordable and accessible way for the general public to begin weighing themselves regularly.³

1899

“OVERWEIGHT”

The term “**overweight**” was first used to describe people in larger bodies.⁵ Diet companies began selling products as solutions to the problem of being “overweight.”

Insurance companies, represented by the Association of Life Insurance Medical Directors of America, presented findings that overweight people have a higher mortality risk based on BMI (a flawed metric that was discussed in Section 1).³ Their data was based almost exclusively on wealthy white men.⁶

EARLY
1900S

WEIGHT LOSS IN THE MEDICAL FIELD

Physicians began to get on board with the idea of weight loss in response to the growing demand of patients seeking weight loss advice. There was still no scientific evidence supporting the health benefits of weight loss, just strong anti-fat cultural bias. By the 1920s, almost every doctor’s office had a scale to track and measure patients’ weights.³

1930
- 40S

DIET PILLS

Diet pills hit the market and grew in popularity, beginning with Bensedrine and progressing to amphetamines (aka speed).

1995

BARIATRIC SURGERY

The first bariatric surgery was performed at the University of Minnesota. The procedure was initially an elective surgery; however, the procedure was redefined as “medically necessary” once bariatric surgeon Howard Payne coined the term “**morbid obesity**” (the word morbid insinuating the life-threatening nature of larger body sizes).



1995

BMI CATEGORIES ESTABLISHED

The World Health Organization (WHO) published a technical report establishing the four BMI categories: *underweight, normal, overweight, and “obese”* (WHO 1995).

1998

NIH CHANGES BMI CATEGORIES

The National Institute of Health (NIH) changed the cutoffs on BMI so that millions of Americans became “overweight” or “obese” overnight. This decision was informed by a report written by the International Obesity Task Force (IOTF) that was **funded primarily by two pharmaceutical companies manufacturing weight loss drugs.**⁷

1998

“OBESITY” AS A DISEASE

Researcher William Dietz established the notion that **“obesity is a disease.”** Dietz along with CDC scientist Ali Mokdad created a series of color-coded maps highlighting the percent of people in a given geographic area labeled as “obese” by BMI standards (see Fig 1). These maps were distributed to the general public and created a powerful image of an “obesity epidemic” spreading across the United States, “proving” that a problem existed and prompting widespread moral panic.

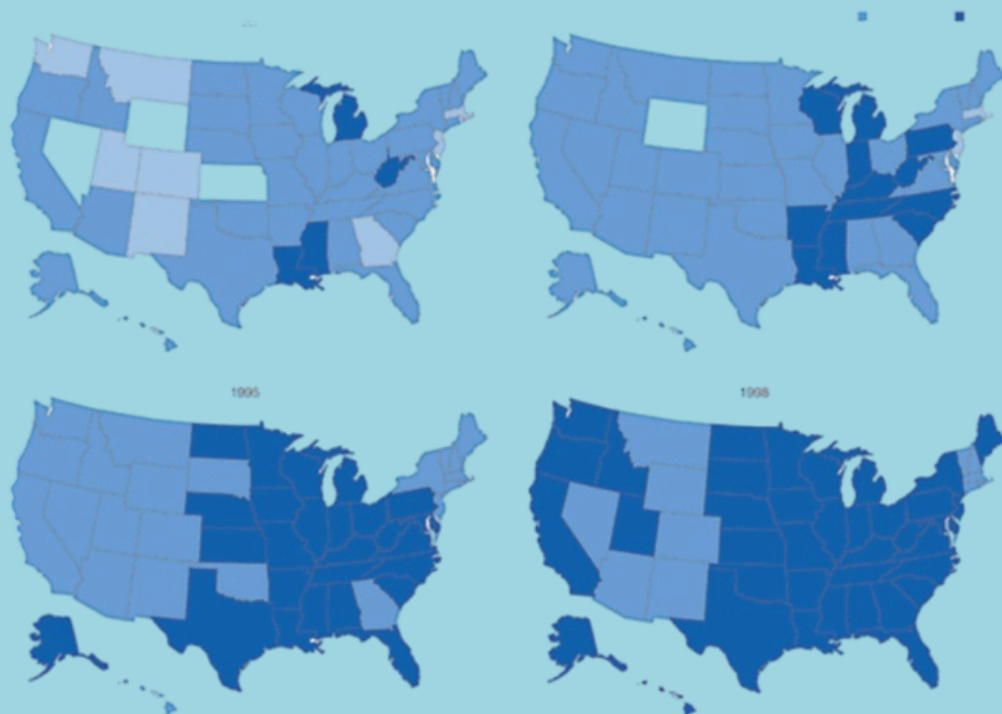
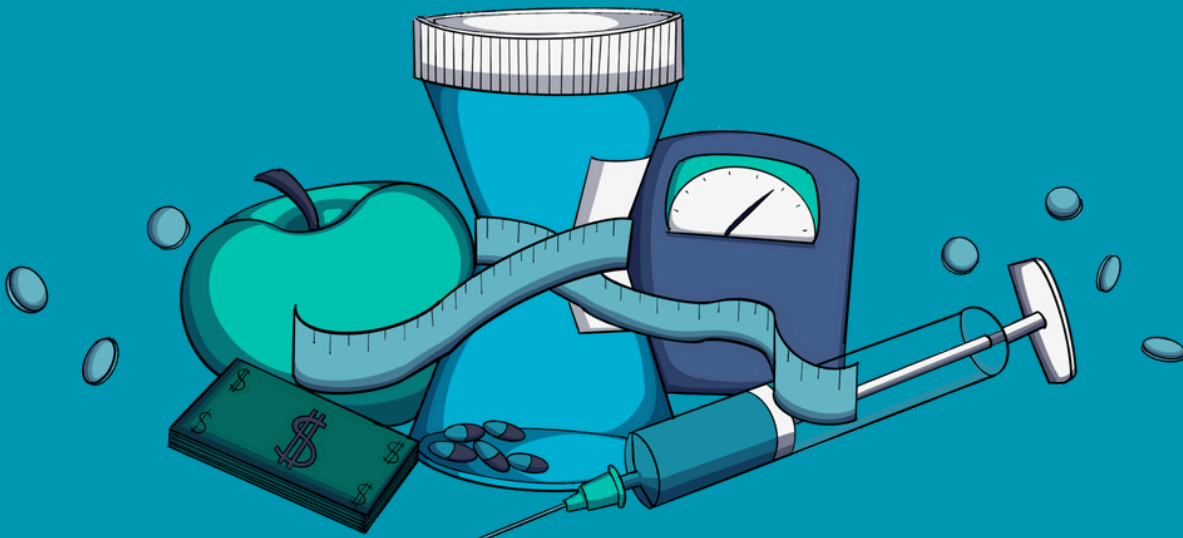


FIG 1. PREVALENCE OF “OBESITY” AMONG U.S. ADULTS FROM YEARS 1991, 1993, 1995, AND 1998 ⁸

Mokdad’s maps, as mentioned in the timeline above, prove to be misleading. The data shows an overall modest increase in average weight in the United States (with the majority of people weighing approximately 3-5 kg more than they did a generation ago), thereby moving tens of millions of people into the “overweight” BMI category.^{6,9} Additionally, those that were already classified as “overweight” gained a small amount of weight (on average <10 pounds) moving them into the “obese category.”²

As authors of one article on the epidemiology of overweight and obesity put it, “The *average* American’s weight gain can be explained by 10 extra calories a day, or the equivalent of a Big Mac once every 2 months.⁹ **Suffice it to say, we are seeing subtle shifts in BMI, not a massive surge consistent with an “epidemic.”**

As demonstrated by this timeline, the pathologization of body size originated from anti-fat bias perpetuated by cultural beauty standards and fueled by the diet industry. The stigmatization of larger bodies preceded the medical field defining “obesity” as a disease, and this stigma is interwoven into the research and practices that support this categorization; **thus, the medicalization of body size is inextricably rooted in systems of oppression.** It is critical to understand the complex origins of the “obesity epidemic” in order to begin dismantling the health inequities that result from the pathologization of size.



THE WEIGHT LOSS INDUSTRY: WHY \$\$\$ MATTERS

From its inception, the diet and weight loss industry has been intertwined with the pathologization of size.

Insurance companies began profiting off of fatphobia as early as 1899 when they presented flawed information about the association of BMI (itself a flawed metric, as discussed previously) and mortality.³ With the emergence of health rationales for weight loss, diet culture swept across the United States in full force in the 1920s and 1930s.^{2, 5}

As the “obesity epidemic” gained traction as a public health issue in the United States, the weight loss industry began mobilizing dollars to fund the research backing the pathologization of body size. In 1998, the NIH lowered the BMI cutoffs, adding nearly 40 million Americans to the “at-risk” weight categories.²

This decision was based on a report by the International Obesity Task force that was funded largely by two pharmaceutical companies manufacturing weight loss drugs.⁷ A number of “obesity experts” with deep financial ties to the diet industry also influenced the change in BMI cutoffs.² **These financial ties matter because industry funding substantially affects research outcomes.**¹⁰⁻¹³

In response to the “alarming” increase in the number of people considered at risk because of their weight, the NIH escalated “obesity” to an all-time-high public health crisis. Budgets for “obesity programs” at the NIH and CDC subsequently increased dramatically.² **“Obesity researchers” now had the power, validity, and funds to continue pumping out biased research supporting the claim that being fat is bad for you.**

In 2013, the American Medical Association officially classified “obesity” as a disease. The weight loss industry spent millions of dollars lobbying members of the AMA to overturn its previous decision (where it had ruled that “obesity” should *not* be considered a disease).^{2, 14} This was a strategic move as it ensured that drug companies, weight loss clinics, and bariatric surgeons would continue to profit financially from the disease label.² Yet again, we see how money influences the medicalization of body size.

Today, the weight loss industry is alive and well- and growing. In 2023, the United States weight loss industry reached an all-time high net worth of \$90 billion and is expected to grow another 4.3% in 2024.¹⁵ With the introduction of Novo Nordik’s Wegovy and Ozempic among others, the market for prescription weight loss drugs more than doubled in 2023, with an estimated net worth of \$11.9 billion.¹⁵ Medical weight loss programs and services continue to flourish as drug manufacturers and commercial diet companies pour millions of dollars into advertising.¹⁵
As long as there are dollars to be made, the diet industry will continue to exploit larger bodies and promote anti-fat “science” in the name of “health and wellness.”

HEALTHISM: HOW MORALITY GETS APPLIED TO MEDICINE

Many arguments that promote the pathologization of size are rooted in elevating the state of being healthy to a moral value rather than an individual's circumstance. Viewing health as a social obligation justifies penalizing those who do not meet this ideal through policies, stigma, and mistreatment. This framework has been called *healthism*.¹⁶ Christy Harrison, author of *Anti-Diet*, summarizes Crawford's work by defining healthism as "the belief that health is a moral obligation, and that people who are 'healthy' deserve more respect and resources than people who are 'unhealthy'".² Similar to the other "isms" (racism, sexism, etc.), healthism is a form of discrimination based on one's health, and it harms people in larger bodies in many ways.

First, healthism places the onus on the individual while failing to recognize the complex and critical role of social determinants of health.¹⁶ When physicians view patients in larger bodies through the lens of healthism, they are motivated to place blame on the individual's behaviors, attitudes, and emotions rather than recognizing the complex factors that contribute to a person's health. Many studies of healthcare students and professionals show biased views that "obese" patients are less likely to comply with treatment^{17,18} and are more personally responsible for their condition.^{19,20}

Healthism as the dominant medical and social narrative makes these views acceptable and does not encourage medical professionals to recognize the systems and access issues at play in their patients' lives.

Healthism is also the means by which providers impose ideals of health on their patients as a central value of life, which further promotes the medicalization of human conditions like size. Health means different things to different people, and our traditional medical definitions leave out a lot of people.²¹ When we treat our patients based on pre-existing notions of what is right or wrong, we fail to recognize our patients' diverse individual values and goals. This approach is so entrenched and normalized, medical ethicists even argue that we need to take a more paternalistic approach to "managing obesity".^{22,23}

This has many parallels to society's treatment of disability. Three common frameworks for viewing disability include the moral model, where disability is caused by moral failings; the medical model, where disability is a "defect in or failure of a bodily system that is inherently abnormal and pathological"; and the social model, where disability is a social construct and the problem lies in an inaccessible society.²⁴

Scholars have used these same lenses to discuss body size,^{25,26} **positing that the medical model pathologizes traits that would not be an issue if not for an inaccessible and biased society.** In this way, the medical establishment imposes moralizing, paternalistic values on patients without their consent or input, making health (as defined by the dominant narrative) unobtainable for people with marginalized identities.

Superimposing morality on individuals' states of health also justifies punishing those who do not meet the medical establishment's standards. Da'Shaun Harrison, a self-identified fat, black, trans-nonbinary disabled person, writes about the abusive power of the medical industrial complex in their book *Belly of the Beast*.²⁷ They write, **"The medical industry, the healthcare industry, and the diet industry all exist to maintain a culture intended to 'discipline' those whose bodies refuse to—and, for many, simply cannot—conform to the standards of health."** This shows up in many ways in healthcare, from verbal and physical abuse to refusal to provide care. This mistreatment is justified, and even encouraged, through healthism.

The promotion of health as a moral obligation has serious consequences for patients in larger bodies. The pathologization of size and its basis in healthism fan the flames of weight bias and discrimination, the consequences of which will be discussed in the following section.

Key Takeaways:

- **Fatphobic beliefs rooted in racism** predated the creation of size as a disease in the medical field.
- As the “obesity epidemic” gained traction as a public health issue in the United States, the **weight loss industry** began mobilizing dollars to fund the research backing the pathologization of body size.
- **Healthism** is the framework in which providers impose ideals of health on their patients as a central value of life, which further promotes the medicalization of human conditions like size.

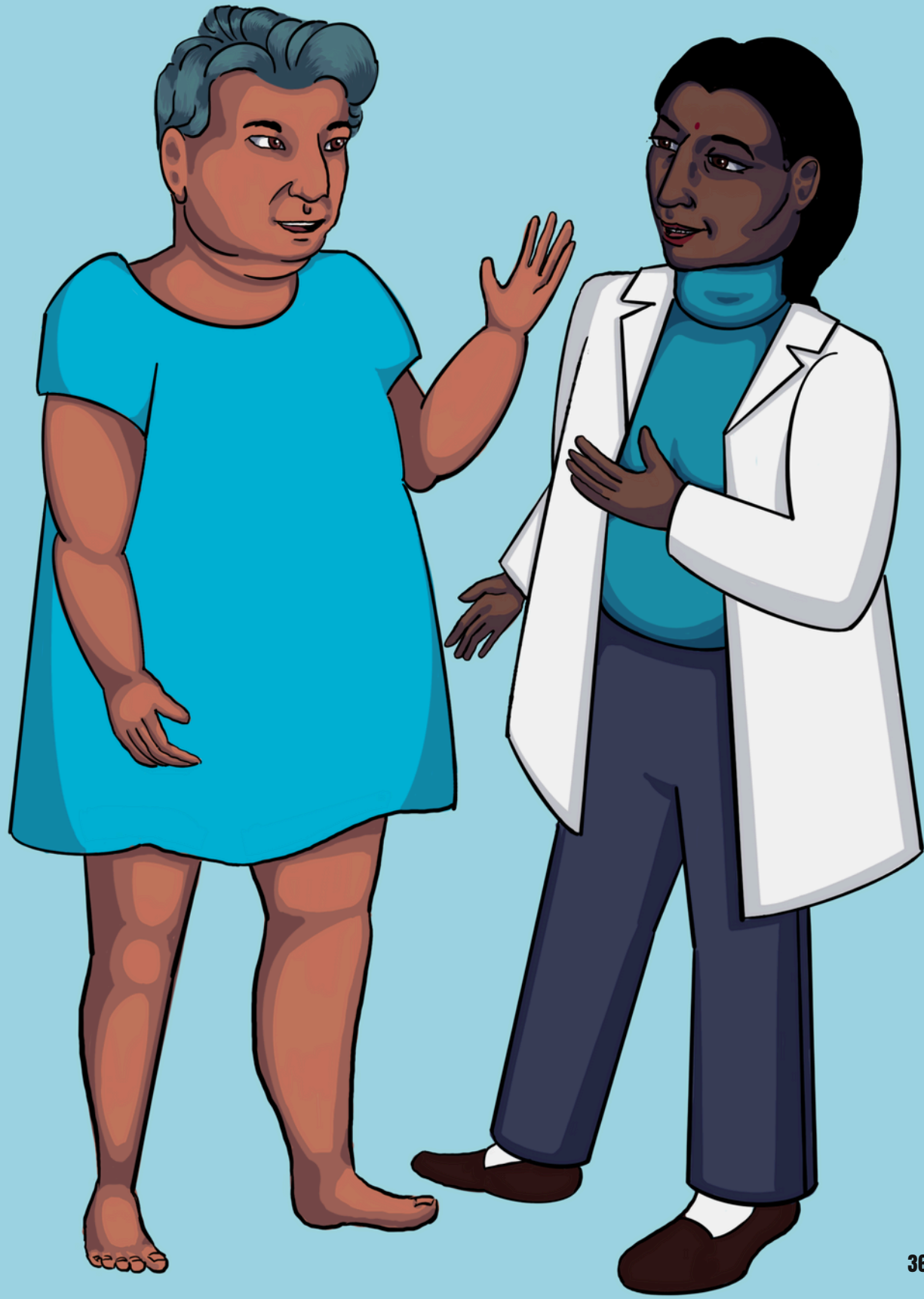
SOURCES

1. Strings S. *Fearing the Black Body*. New York: New York University Press; 2019.
2. Harrison C. *Anti-Diet: Reclaim Your Time, Money, Well-Being, and Happiness Through Intuitive Eating*. New York: Little, Brown Spark; 2019.
3. Schwartz H. *Never Satisfied*. Free Pr; 1986.
4. Bivins R, Marland H. Weighting for health: Management, measurement and self-surveillance in the modern household. *Social History of Medicine*. 2016;29(4):757-80. doi:10.1093/shm/hkw015.
5. Veit HZ. *Modern Food, Moral Food: Self-Control, Science, and the Rise of Modern American Eating in the Early Twentieth Century*. Chapel Hill, NC: University of North Carolina Press; 2013.
6. Flegal KM et al. Association of all-cause mortality with overweight and obesity using standard body mass index categories: A systemic review and meta-analysis. *JAMA*. 2013;309(1): 71-82.
7. Oliver JE. *Fat Politics: The Real Story behind America's Obesity Epidemic*. Oxford, UK: Oxford University Press; 2005.
8. Mokdad AH, Serdula MK, Dietz WH, Bowman BA, Marks JS, Koplan JP. The Spread of the Obesity Epidemic in the United States, 1991-1998. *JAMA: the journal of the American Medical Association*. 1999;282(16):1519-1522. doi:10.1001/jama.282.16.1519
9. Campos et al. The epidemiology of overweight and obesity: public health crisis or moral panic? *International Journal of Epidemiology*. 2006;35(1):55-60.
10. Ahn R et al., Financial Ties of Principal Investigators and Randomized Controlled Trial Outcomes: Cross Sectional Study, *BMJ* 356: 16770 (2017)
11. Bekelman JE et al., Scope and Impact of Financial Conflicts of Interest in Biomedical Research, *JAMA*, 289(4): 454-465 (Jan. 22/29, 2003)
12. Lundh A et al., "Industry Sponsorship and Research Outcome," *Cochrane Database of Systematic Reviews* 2: MR00003 (2017)
13. Lexchin J et al., Pharmaceutical Industry Sponsorship and Research Outcome and Quality Systematic Review, *BMJ*, 326:1167 (2003)
14. Chastain R. Reader Question – Weight Loss Industry Big Think Part 1. Weight and healthcare newsletter. 2023. Available at: <https://weightandhealthcare.substack.com/p/reader-question-weight-loss-industry>. Accessed 15 Aug 2024.
15. LaRosa J. U.S. Weight Loss Industry Grows to \$90 Billion, Fueled by Obesity Drugs Demand. Market Research. Published [March 6, 2024]. Accessed [August 14, 2024]. <https://blog.marketresearch.com/u.s.-weight-loss-industry-grows-to-90-billion-fueled-by-obesity-drugs-demand>
16. Crawford R. Healthism and the medicalization of everyday life. *International Journal of Health Services*. 1980; 10(3): 365-388.

SOURCES

17. Puhl R, Wharton C, Heuer C. Weight bias among dietetics students: implications for treatment practices. *J Am Diet Assoc.* 2009 Mar;109(3):438-44. doi: 10.1016/j.jada.2008.11.034. PMID: 19248859.
18. Persky S, Eccleston CP. Medical student bias and care recommendations for an obese versus non-obese virtual patient. *Int J Obes (Lond).* 2011 May;35(5):728-35. doi: 10.1038/ijo.2010.173. Epub 2010 Sep 7. PMID: 20820169; PMCID: PMC3000449.
19. Pantenburg B, Sikorski C, Luppia M, et al. Medical students' attitudes towards overweight and obesity. *PLoS One.* 2012;7(11):e48113. doi:10.1371/journal.pone.0048113
20. Phelan SM, Dovidio JF, Puhl RM, Burgess DJ, Nelson DB, Yeazel MW, Hardeman R, Perry S, van Ryn M. Implicit and explicit weight bias in a national sample of 4,732 medical students: the medical student CHANGES study. *Obesity (Silver Spring).* 2014 Apr;22(4):1201-8. doi: 10.1002/oby.20687. Epub 2014 Jan 9. PMID: 24375989; PMCID: PMC3968216.
21. Lee JA., Pausé CJ. Stigma in Practice: Barriers to Health for Fat Women. *Frontiers in Psychology.* 2016(7) doi:10.3389/fpsyg.2016.02063
22. Pope, Thaddeus Mason, "Limiting Liberty to Prevent Obesity: Justifiability of Strong Hard Paternalism in Public Health Regulation" (2014). Faculty Scholarship. Paper 279. <http://open.mitchellhamline.edu/facsch/279>
23. Skipper R. Obesity: Towards a System of Libertarian Paternalistic Public Health Interventions, *Public Health Ethics*, Volume 5, Issue 2, July 2012, Pages 181–191, <https://doi.org/10.1093/phe/phs020>
24. Olkin R. Could you hold the door for me? Including disability in diversity. *Cultur Divers Ethnic Minor Psychol.* 2002 May;8(2):130-7. doi: 10.1037/1099-9809.8.2.130. PMID: 11987590.
25. Harjunen H. Exploring Obesity through the Social Model of Disability. *Gender and Disability Research in the Nordic Countries. Studentlitteratur 2004 (Lund)*
26. Brandon T, Pritchard G (2011) 'Being fat': a conceptual analysis using three models of disability, *Disability & Society*, 26:1, 79-92, DOI: 10.1080/09687599.2011.529669
27. Harrison DL. *Belly of the Beast.* Berkeley, CA: North Atlantic Books; 2021.

CHAPTER 3: **WEIGHT STIGMA IN HEALTHCARE**



INTRO

On May 11, 2018, Canadian woman Ellen Maud Bennett, died at the age of 64 after being diagnosed with inoperable cancer. She received the diagnosis shortly before her death. She used her obituary to speak of the weight stigma she experienced in the medical profession.

“Over the past few years of feeling unwell she sought out medical intervention and no one offered any support or suggestions beyond weight loss. Ellen's dying wish was that women of size make her death matter by advocating strongly for their health and not accepting that fat is the only relevant health issue.”¹

Unfortunately, this is not a singularity. As the previous chapter on the pathologization of size explains, weight-loss and health became moral imperatives. With this, the way the medical community approached weight also shifted. BMI became synonymous with health and any deviation from health was typically considered to be a direct result of weight.^{7,8} In the media, people in larger bodies tend to be portrayed as undesirable, with few romantic partners, and are more often shown eating—another way in which the idea of personal responsibility for one's body size is enforced.²

Such pervasive negative influences on the perception of those with fat bodies clearly translates to the healthcare workforce. There is increasing evidence that those in the healthcare field hold negative attitudes towards their fat patients. One study looked at the role of “obesity” bias in students, and concluded that weight bias is “commonly observed by students in health disciplines.”³ The evidence that healthcare workers hold strong internalized bias against fat people is clear.

“

"Ellen's dying wish was that women of size make her death matter by advocating strongly for their health and not accepting that fat is the only relevant health issue."

”

In this chapter, we will explore the effects of weight stigma in healthcare including healthcare avoidance, how weight stigma affects health outcomes, and the intersection of multiple marginalized identities included within weight bias. Further, we will provide a potential framework for health career students to promote weight neutrality in healthcare.

THE IMPACT OF WEIGHT STIGMA ON HEALTH OUTCOMES

In this section, we will discuss how weight stigma affects both physical and mental health. It is important to note that for every disparity which people in larger bodies face, there are compounded disparities that people with multiple intersectional identities may also experience. Several studies have found that rates of weight-based harassment and discrimination is on par with rates of race-based discrimination.

Adolescents from various intersecting sociodemographic and weight-statuses groups are particularly vulnerable to certain types of harassment.” They found that among adolescents, an age-group of unique susceptibility to societal pressure, “weight- and race-based harassment (35.3% and 35.2%, respectively)

was most prevalent, followed by sexual harassment (25.0%) and socioeconomic status-based harassment (16.1%).”⁴ Weight-based bullying within youth and adolescents appears much more prevalent among sexual and gender minorities and was much more common than other forms of bullying.⁹



"Among adolescents, an age-group of unique susceptibility to societal pressure, “weight- and race-based harassment (35.3% and 35.2%, respectively) was most prevalent”



However, weight is an often overlooked form of discrimination, and the health effects of weight discrimination, particularly in those with other marginalized identities, is not well studied. Current evidence suggests that “obesity’ discrimination has increased exponentially over past decades, to a level that compared with racial discrimination in the USA by the first decade of this century.”⁴

There is no doubt that discrimination on such a widespread and systematic scale has negative health effects. One study found that people in larger bodies “ are 32% more likely to develop depression compared with their normal-weight counterparts” and that this statistic “remained significant following adjustment for relevant variables

including body weight.”⁴ This suggests that these increased depression rates are associated with weight stigma rather than “obesity per se.”⁴

Therefore, while a medical diagnosis of “obesity” is often lauded as a culprit of increased risk of mental illness, this in fact, may not be true—**it is possible that it is weight stigma, rather than weight itself, that leads to increased risk of mental illness for those in larger bodies.**

While easy to believe that weight stigma can affect mental health, it may be more difficult to understand that weight stigma can affect physical health as well, leading to poor health outcomes and increased all-cause mortality.^{4,5} People in larger bodies still had a 60% increased risk of death when controlled for BMI, suggesting that the increased risk is due to weight stigma and discrimination.⁴ One study suggested that the “mere perception of oneself as being overweight, across the BMI spectrum (i.e., even among individuals at a ‘normal’ BMI), is prospectively associated with biological markers of poorer health.”⁵ The power of weight stigma is so strong that internalized weight stigma has physiological effects on health at the individual level.

Even with clear evidence that weight stigma can lead to poorer health effects on a molecular level, little research exists on the effect of weight discrimination on a macro level. There is insufficient social pressure to increase funding and research support for weight stigma over “obesity” treatment research, even though the few studies that do exist have found that “Weight stigma was positively associated with obesity, diabetes risk, cortisol level, oxidative stress level, C-reactive protein level, eating disturbances, depression, anxiety, body image dissatisfaction and negatively associated with self-esteem.”⁶

Why is there so little research into how weight stigma affects conditions traditionally associated with weight, such as cardiovascular disease and diabetes?

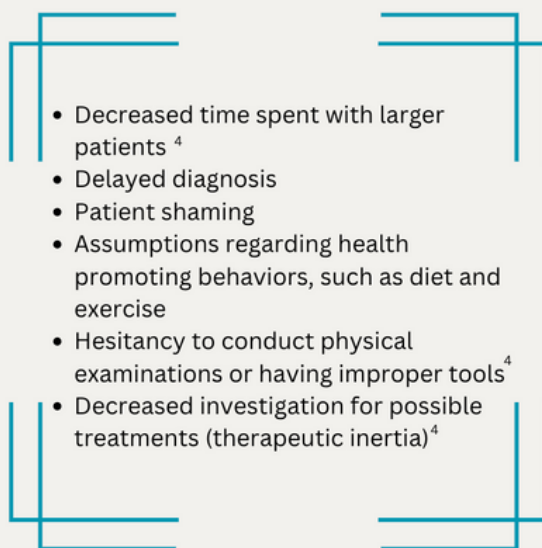
One such reason could be a lack of education surrounding just how harmful weight stigma is on health. Another could be that there is little incentive to change existing practices, as the weight loss industry is one of the most profitable industries, both at the pharmacological and cosmetic level. In a society where profit is paramount, weight stigma simply does not fit into the prescribed narrative.

While evidence suggests that long-term weight loss is not sustainable for >90% of people, many companies in the weight loss industry capitalize on this fact, increasing profits to over \$90 billion in 2023, with projections to increase to over \$150 billion with the spike in weight loss pharmaceuticals such as Ozempic and Wegovy.¹¹

Many medical organizations continue to recommend behavior-based intervention as first-line for weight loss, despite its inefficacy. This further contributes to weight stigma in the medical field and increases the harm patients must overcome when seeking medical attention.



Another way that weight stigma manifests itself is within the physician or healthcare provider and how their anti-fat biases impact the way they practice medicine. As mentioned in the introduction, delayed diagnosis of potentially fatal conditions can lead to higher mortality for larger bodied patients. Some examples of the outcomes of physician weight bias are:

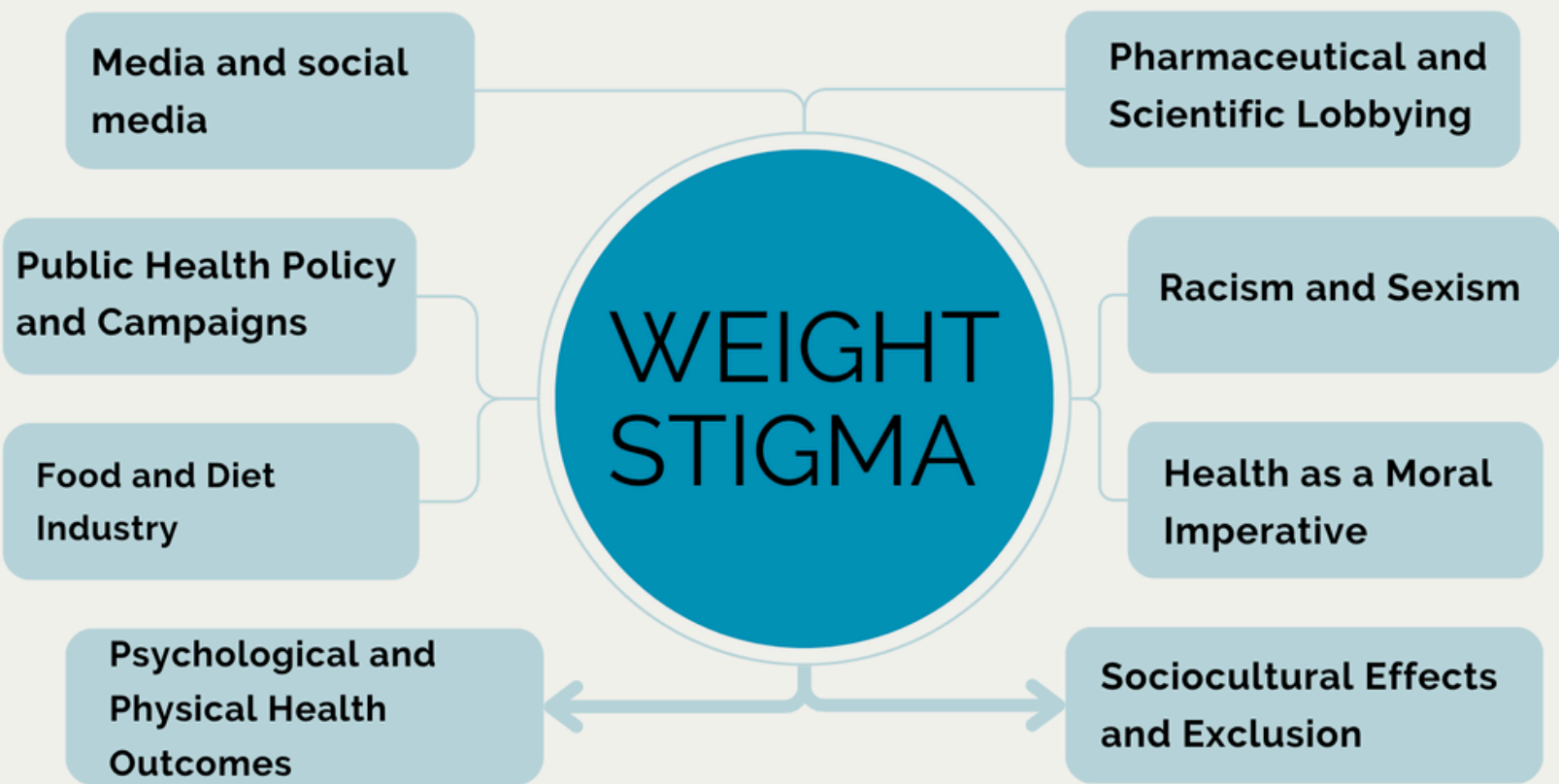
- 
- Decreased time spent with larger patients ⁴
 - Delayed diagnosis
 - Patient shaming
 - Assumptions regarding health promoting behaviors, such as diet and exercise
 - Hesitancy to conduct physical examinations or having improper tools ⁴
 - Decreased investigation for possible treatments (therapeutic inertia) ⁴

All of these manifestations of weight stigma in healthcare providers can lead to a decrease in trust in the therapeutic relationship. As such, people in larger bodies have higher rates of healthcare avoidance, both for active medical issues and preventive care.⁵ Naturally, people will avoid a place where they are told that their body size is the problem and that they are not engaging in health-promoting behaviors, even though a trip to the doctor is in and of itself a health-promoting behavior.

Further, physicians who are hesitant to conduct physical examinations may instill a sense of disgust, like a fat-bodied patient does not deserve the same level of care as a thin body because their body is inherently detestable. Some providers rebrand their dislike of fat bodies as care – claiming to address weight stigma while persistently viewing fatness as a disease.¹² Weight stigma can also affect those in thin bodies, though such bias and stigma presents differently. For example, some physicians assume people who are thinner are healthy, disregarding abnormal lab values as erroneous and thereby missing important diagnoses.

Insurance coverage, though a complete topic in and of itself, also affects the way that physicians practice medicine for larger people. Many insurance companies have BMI cutoffs for certain tests and procedures, making physicians unable to order these without prior authorization—a barrier that increases the activation energy for a physician to offer said test or procedure. Without providers actively working to challenge their biases and provide equitable care, weight stigma will inevitably affect their patients in many quantifiable and intangible ways.

POTENTIAL CAUSES OF WEIGHT STIGMA IN MEDICINE



Adapted from: <https://link.springer.com/article/10.1007/s13679-023-00495-3>

BREAK WEIGHT BIAS **BREAK WEIGHT BIAS** **BREAK WEIGHT BIAS** **BREAK WEIGHT BIAS** **BREAK WEIGHT BIAS**

WEIGHT BIAS IN MEDICAL EDUCATION

BREAK WEIGHT BIAS **BREAK WEIGHT BIAS** **BREAK WEIGHT BIAS** **BREAK WEIGHT BIAS** **BREAK WEIGHT BIAS**

Weight stigma within healthcare oftentimes begins or is further perpetuated in medical education and is unfortunately pervasive in healthcare--amongst “physicians, trainees, medical students and dietitians.”⁵ Weight stigma within medical education not only impacts the care of patients in larger bodies--it also negatively impacts medical trainees.

For example research shows that medical students with a higher BMI state that clinical work can be challenging. Furthermore, those who have a higher BMI and internalize ‘anti-fat’ attitudes have more depressive symptoms and alcohol or substance abuse.⁵ The infographic on the next page shows the three ways that weight bias is further perpetuated in medical education.

BREAK WEIGHT BIAS **BREAK WEIGHT BIAS** **BREAK WEIGHT BIAS** **BREAK WEIGHT BIAS** **BREAK WEIGHT BIAS**

Weight Bias in Medical Education

Thin Preference

"In year two, he attended an educational summit on obesity put on by one of his professors. As part of the summit [in medical school], Yan took an implicit bias test that identified his slight bias toward thinner people."¹⁵

A 2018 study that examined small cohorts of medical school students showed that across cohorts who took the Implicit Association Test (IAT) on attitudes toward weight, 70% of students had thin preference, 11% had fat preference and 18% had no preference¹⁶



Lack of Education

"Doctors traditionally learn nothing about obesity, not in medical school or residency," says Dr. Scott Kahan, "What we learned is essentially just: 'Obesity is very prevalent and you're going to see it in lots of your patients. And it's really important for people to eat less and exercise more'; that's pretty much it."¹⁵

With the lack of education of obesity also comes the lack of medical education with patients in a larger body. Due to lack of critical discussions and nuance around obesity and weight, there is simultaneously less education on weight bias.

Weight-Normative Approach

"The whole PowerPoint presentation [in nursing school] was full of microaggressions; it was so sham-ing toward people in larger bodies. The emphasis was on dieting and restricting, it sounded dangerous, but I couldn't leave. And now it will be on the final!" Julie had fought hard to recover from anorexia nervosa."¹⁷

The weight-normative approach which implies that weight is under individual control and that weight loss results in improved health is the norm in medical education which negatively impacts future patients and students themselves who have been personally impacted by weight bias.⁵



BUT ISN'T BEING FAT BAD FOR YOU?

There are few single measures that carry as much weight as BMI, and it can be easy to understand why. With one convenient and inexpensive measurement, BMI is commonly used to predict a slew of other health risks including cardiovascular events, diabetes, and mortality. It's the miraculous standard, labeling patients as healthy or unhealthy from one number or appearance alone.

For all its convenience, BMI is a poor capture of metabolic and cardiovascular health. BMI can't distinguish, for instance, what percentage of weight comes from a person's fat or muscle, or how weight is distributed around the body. Pro athletes often have BMIs that could cause concern at a doctor's visit. Based on values from the NFL website, only two players on the Denver Broncos 2023 roster meet the normal BMI criteria of 18.5 to 24.9.

When associating BMI with health outcomes, we make a rather key assumption - that a person's weight reflects their adherence to healthy behaviors such as nutritious diet and exercise. If a person lost weight, for example, they did so by choosing healthy habits. Losing weight on a high-fat diet and sedentariness does not seem intuitive.

And yet, we know that normal BMI and healthy behavior is not correlated for everyone. It's not true for most of the Denver Broncos, nor for the medical student who remains thin on a regular diet of pizza.

By assuming that BMI is associated with behavior and health outcomes, we already have the foundation to create a false correlation that behavior is synonymous with health outcomes. This assumption is not only harmful to a person's mental wellbeing, but also potentially dangerous to physical health.



Another argument equates smoking with BMI and "unhealthy" eating habits. If smoking is bad for you, then so is having a high BMI, right? Again, this assumes that body size is a modifiable behavior, rather than a state of being, just like smoking is a behavior.

Furthermore, numerous studies actually show that all-cause mortality is at its lowest point when BMI is actually in the “overweight” range and “class 1 obesity” has a null association with mortality.¹³ Many studies that correlate body weight with adverse health outcomes do not control for weight stigma. Such studies point to how as the United State’s average BMI increased, health outcomes decreased. However, these studies fail to identify other aspects of public health that changed in the last 75 years – such as the rise of dieting, which in turn leads to weight cycling, a phenomenon which is now being identified as harmful to health.

Clearly, using BMI is a matter of convenience. It’s a quantifiable way to justify maintaining the status quo– but at what cost? Do the studies truly show what we expect them to, if we look beyond the data at the assumptions upon which the study was built?

POTENTIAL CAUSES OF INCREASED BMI

- YOUR GENETICS
- STEROID PRESCRIPTION/USE
- DECREASED MOBILITY
- CHRONIC STRESS
- POOR SLEEP
- CERTAIN MEDICATIONS (E.G. ANTIDEPRESSANTS)
- HORMONE DISORDERS
- DECREASED ACCESS TO FOOD/NUTRITION
- PSYCHIATRIC CONDITIONS
- MANY OTHERS

Note: “increased BMI” does not hold a moral value nor does it inherently determine health status. Many of these causes are systematically/socially/genetically determined -- which highlights how BMI is a poor metric of health and how BMI/body size is not equivalent to personal behavior.

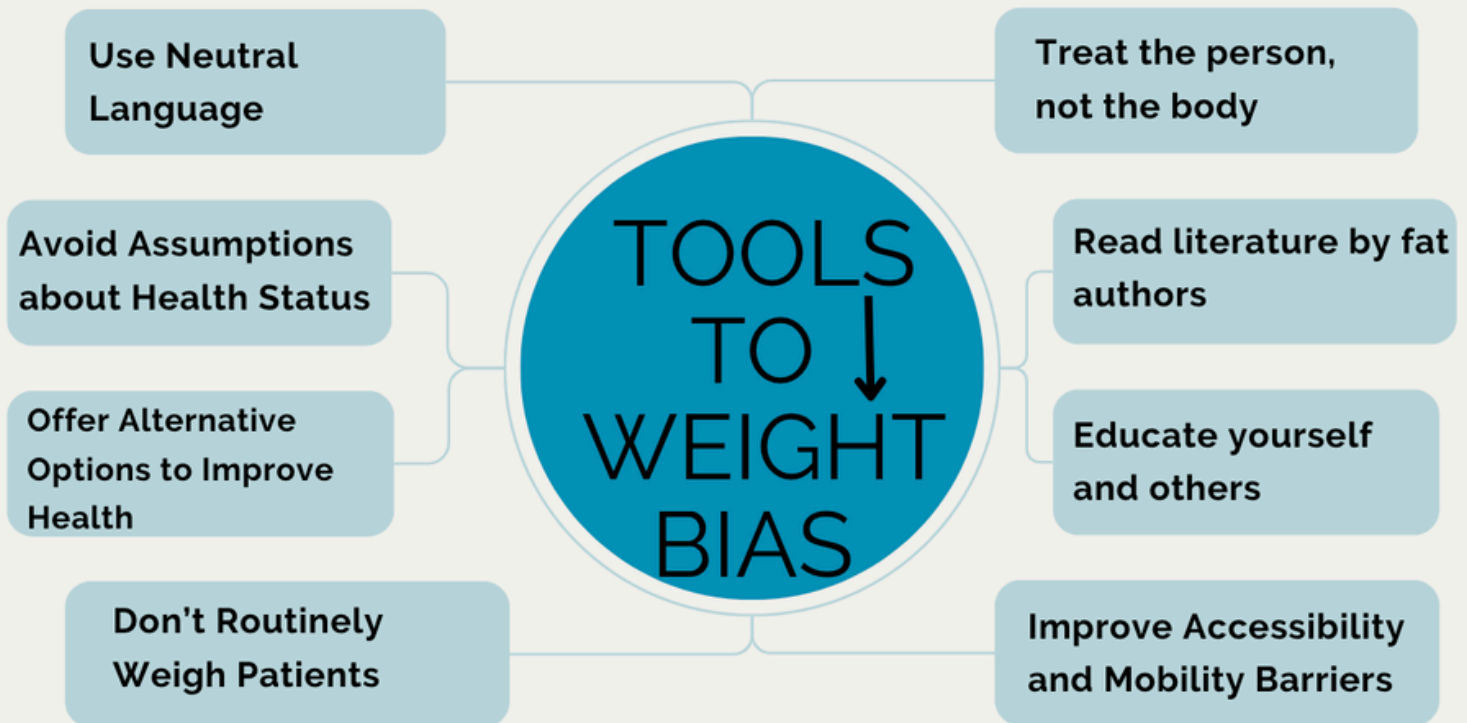
Beyond BMI: Potential Causes of Increased Weight

The table below is by no means an exhaustive list of potential causes of weight gain and increased BMI. It is important to note that none of these factors are indicative of lower health status in and of themselves. However, identifying some of these factors can help to demonstrate that BMI does not equate to a specific behavior in which someone may engage.

Furthermore, this table addresses potential factors that impact someone’s body size on an individual level. There are a vast number of socioeconomic factors and structural causes of increased weight which have nothing to do with individuals. These factors fall under the “chronic stress” umbrella, but also may impact someone’s access to regular healthcare, grocery stores, public gyms or parks, or safe locations to sleep. To disregard such factors is a dangerous misstep in medicine and loses sight of the context of the society which may in and of itself limit someone’s control of their body size. Understanding this, it is clear to see that while individual factors are at play when discussing BMI, this is also a prominent social justice issue. Weight bias can be viewed through this lens and be seen as another form of oppression, especially for people with multiple marginalized identities.

AN ALTERNATIVE APPROACH:

WAYS TO MANAGE AND ADDRESS WEIGHT BIAS IN MEDICINE



ACTIVITY

--	--

Challenge yourself:
Identify at least 2 action items to combat weight stigma in medicine

--	--

Key Takeaways:

- **Weight bias** has numerous impacts on delivery of healthcare, including time spent with patients and the physical exam
- **Medical education propagates weight bias** and in doing so, promotes weight-normative, rather than weight-inclusive practices
- **Medical education lacks nuance** and often over-values the utility of BMI and equates weight with behavior
- **Weight bias in medical education causes harm**, both for students and their future patients



SOURCES

1. “Ellen Bennett Obituary (2018) - Legacy Remembers.” Accessed September 9, 2024. <https://www.legacy.com/obituaries/name/ellen-bennett-obituary?pid=188266075>.
2. Greenberg BS, Eastin M, Hofschire L, Lachlan K, Brownell KD. Portrayals of overweight and obese individuals on commercial television. *Am J Public Health*. 2003 Aug;93(8):1342-8. doi: 10.2105/ajph.93.8.1342. PMID: 12893625; PMCID: PMC1447967.
3. Puhl RM, Luedicke J, Grilo CM. Obesity bias in training: attitudes, beliefs, and observations among advanced trainees in professional health disciplines. *Obesity (Silver Spring)*. 2014 Apr;22(4):1008-15. doi: 10.1002/oby.20637. Epub 2013 Dec 4. PMID: 24124078; PMCID: PMC3968226.
4. Westbury S, Oyebode O, van Rens T, Barber TM. Obesity Stigma: Causes, Consequences, and Potential Solutions. *Curr Obes Rep*. 2023 Mar;12(1):10-23. doi: 10.1007/s13679-023-00495-3. Epub 2023 Feb 14. PMID: 36781624; PMCID: PMC9985585.
5. Tomiyama, A., Carr, D., Granberg, E. et al. How and why weight stigma drives the obesity ‘epidemic’ and harms health. *BMC Med* 16, 123 (2018). <https://doi.org/10.1186/s12916-018-1116-5>
6. Wu YK, Berry DC. Impact of weight stigma on physiological and psychological health outcomes for overweight and obese adults: A systematic review. *J Adv Nurs*. 2018 May;74(5):1030-1042. doi: 10.1111/jan.13511. Epub 2017 Dec 8. PMID: 29171076.
7. Brown, S. 2023. “How the Use of BMI Fetishizes White Embodiment and Racializes Fat Phobia.” *AMA Journal of Ethics* 25, no. 6: E535–539.
8. Armstrong, D.B., Dublin, L.I., Wheatley, G.M., and Marks, H.H. 1951. “Obesity and Its Relation to Health and Disease.” *JAMA* 147, no. 11: 1007–1014.
9. Bucchianeri, M.M., Gower, A.L., McMorris, B.J., and Eisenberg, M.E. 2016. “Youth Experiences with Multiple Types of Prejudice-Based Harassment.” *Journal of Adolescence* 51: 68–75.
10. Puhl, R.M., Himmelstein, M.S., and Watson, R.J. 2019. “Weight-Based Victimization among Sexual and Gender Minority Adolescents: Findings from a Diverse National Sample.” *Pediatric Obesity* 14, no. 5: e12514.
11. Beasley, Diana. 2024. “Weight-Loss Drug Forecasts Jump to \$150 Billion as Supply Grows.” *Reuters*. May 28, 2024.
12. Cardel, M.I., Newsome, F.A., Pearl, R.L., et al. “Patient-Centered Care for Obesity: How Healthcare Providers Can Treat Obesity While Actively Addressing Weight Stigma and Eating Disorder Risk.” *Journal of the Academy of Nutrition and Dietetics*. Accessed September 9, 2024.
13. Flegal, K.M., Kit, B.K., Orpana, H., and Graubard, B.I. 2013. “Association of All-Cause Mortality with Overweight and Obesity Using Standard Body Mass Index Categories: A Systematic Review and Meta-Analysis.” *JAMA* 309, no. 1: 71–82.
14. Verhaegen AA, Van Gaal LF. Drugs That Affect Body Weight, Body Fat Distribution, and Metabolism. [Updated 2019 Feb 11]. In: Feingold KR, Anawalt B, Blackman MR, et al., editors. *Endotext* [Internet]. South Dartmouth (MA): MDTText.com, Inc.; 2000-.
15. Noguchi, Yuki. Obesity training in medical school leaves doctors ill-prepared to treat patients. *NPR*. January 31, 2023.
16. Geller, Gail and Watkins, Paul. Addressing Medical Students’ Negative Bias Towards Patients with Obesity Through Ethics Training. *AMA J Ethics*. 2018;20(10):E948-959. doi: 10.1001/amajethics.2018.948.
17. Brown, Heather and Ellis-Ordway, Nancy. *Weight Bias in Health Education: Critical Perspectives for Pedagogy and Practice*. Page 73. Taylor & Francis, 2021.

CHAPTER 4:

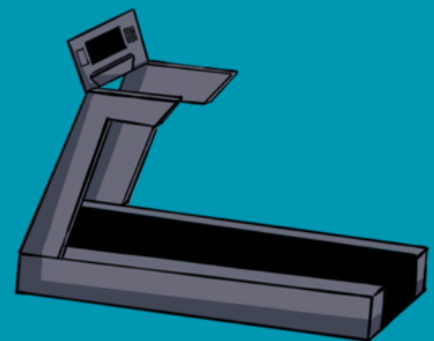
NAVIGATING NUTRITION AND DISORDERED EATING IN A DIET CULTURE ERA



HEALTH IS MORE THAN DIET AND EXERCISE

Social and structural factors such as racism, economic instability, housing instability, and food security play a significant role in shaping health. These factors reflect problems that operate at a level beyond what doctors and patients are often equipped to mutually address. Although diet plays a much smaller role in supporting health, social narratives about one's personal responsibility over their health and health behaviors, such as diet, are pervasive. Therefore, diet becomes a common conversation between healthcare providers and patients. By shifting perspective about the role of diet in health, a physician can support healthcare engagement, make proper diagnoses, and connect patients with necessary resources.

In this section, we will provide an overview of important considerations when discussing diet with patients. First, we will address social misperceptions about the role of diet in health. Next, we will address myths about and provide strategies for addressing disordered eating in your clinic. Finally, we will review considerations for supporting your patient in adopting health-supporting, self-directed eating behaviors. We will also provide prompts to consider how your relationship with food and body image are relevant to your medical education and practice. We envision a future where the doctor's office is a safe space for patient's of all sizes to discuss their relationship with food



CORRECTING MISPERCEPTIONS ABOUT FOOD

YOU CANNOT TELL WHAT SOMEONE EATS BASED ON THEIR BODY SIZE OR SHAPE

Physicians often fall into the trap of making assumptions about a person's dietary habits based on BMI or appearance alone. These assumptions are rooted in the belief that those with low BMIs are engaging in "healthy" food practices, while those with high BMIs are "unhealthy" when it comes to what and how much they're eating. As discussed in previous sections of this guide, BMI is not a reliable tool for measuring one's health. Similarly, body size is not indicative of one's dietary habits and whether or not those habits are "healthy" or "unhealthy." To illustrate this point, one study showed that the adoption of "healthy lifestyle choices", including eating five or more servings of fruits and vegetables daily, was associated with decreased mortality *regardless of BMI*.¹ Providers must learn to take size out of the equation and focus on supporting patients and their relationship to food, whatever that may look like to the individual.

CATEGORIZING FOODS AS "HEALTHY" AND "UNHEALTHY" OR "GOOD" AND "BAD" LEAVES OUT IMPORTANT NUANCES.

How our diets impact our health is highly variable and related to numerous factors, including genetic differences, current health status, stress, and access to quality culturally appropriate food. Broadly generalizing foods as healthy or unhealthy, good or bad, attaches a moral value to food choice. This black and white thinking lends itself to "good" and "bad" days of eating, rather than recognizing a health-supporting diet will contain a mixture of foods based on nutrient profile, personal taste and preference, seasonality, access, social conditions, and more.

FOOD SUPPORTS MENTAL HEALTH, PLEASURE, CULTURE, AND CONNECTION, AND IS NOT JUST FUEL.

As mentioned in point two, food can serve many purposes. Some people may value the role of food in culture and connection over the role food plays in providing energy. Leave room for your patient to tell you how they value food in their life before orienting them to your preference for them.

CORRECTING MISPERCEPTIONS ABOUT FOOD

FOOD PROVIDES ESSENTIAL NUTRIENTS, BUT IS NOT A CURE-ALL.

Undernourishment and nutrient deficiencies are specific contexts in which food can be supportive. However, for some people, additional measures such as supplements might be important. Food is not a cure-all, and many health benefits patients feel from diet changes can be attributed to a placebo effect from making and sticking to diet changes.² One's food access is largely reliant upon structural factors which impact health to a greater extent than the food itself.³ Finally, nutrition research tends to show associations (not causation), is highly flawed in measurement, and samples often include only a narrow part of the population. Thus, it is nearly impossible to make a conclusive statement about the role of any one food or dietary pattern in health. We must place diet in a holistic context.

FOOD SECURITY IS ABOUT MORE THAN MONEY FOR FOOD

National estimates regarding the prevalence of food insecurity primarily focus on having money for food. However, there are many factors that might affect one's food security beyond money for food, including transportation access, neighborhood and geographic access, cultural preferences, family context, barriers from occupational strain, and mental and emotional health.^{4,5} For many people, simply getting enough food is the priority. Adding additional labels about whether the food one has access to is "good" or "bad" is stigmatizing. Lack of food access, for whatever reason, can affect one's mental/emotional relationship with food and their body. Screening patients for food security beyond having money for food (e.g., asking if they have enough food to eat on a consistent basis that meets their preferences) is a first step in promoting your patients health.



EATING DISORDERS & DISORDERED EATING

Popular media, medicine, and science are guilty of promoting stereotypes about who suffers from eating disorders: skinny, white, affluent girls (SWAG).⁶ This stereotype emerged because people fitting the SWAG narrative were more likely to receive concern about and treatment for challenges with disordered eating. As mentioned in other parts of this guide, a historical form of oppression has been to promote white, thin bodies as the ideal. Subsequently, most of our current treatment paradigms for eating disorders are designed for skinny, white, affluent girls,⁷ and this group is most often represented in eating disorders treatment research.⁸ These factors contribute to the stereotypical belief that eating disorders are always about the pursuit of thinness, leading to missed diagnoses and potentially years of improper or no treatment, particularly for individuals in larger bodies.

In reality, we know that disordered eating behaviors do not discriminate based on weight status, socioeconomic status, race, ethnicity, or culture; in fact, they disproportionately affect people with higher levels of trauma and oppression, including weight stigma.⁷ Eating disorders are psychological disorders, meaning you cannot tell whether someone has one by how they look. Eating disorders and disordered eating behaviors are triggered by a multitude of factors beyond a pursuit of thinness or body ideals, including genetic factors, trauma history, food access and sufficiency, occupation strain, and more.⁹ However, because of the SWAG stereotype, disordered eating and eating disorders are generally poorly understood and many people go undiagnosed.¹⁰

EATING DISORDERS & DISORDERED EATING

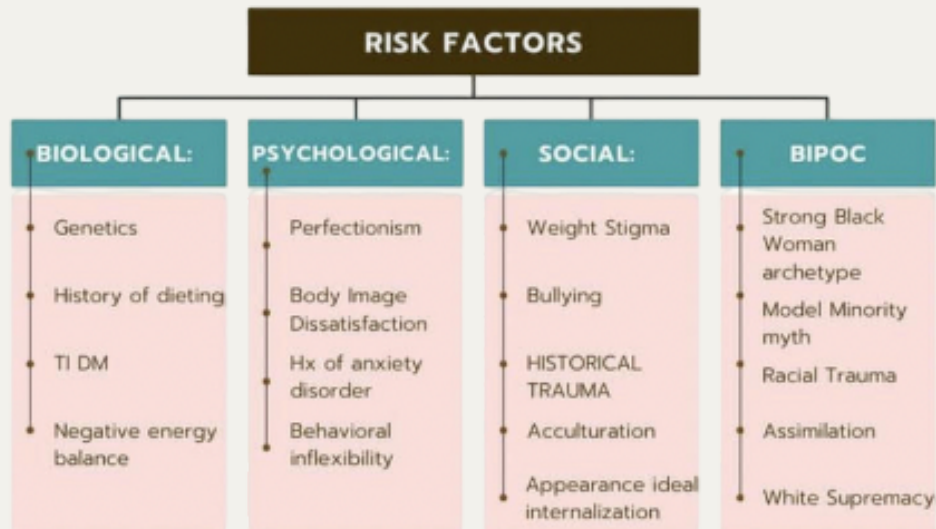
First, it is important to recognize that disordered eating behaviors and clinically diagnosed eating disorders are not the same thing. The diagnostic criteria for eating disorders are exclusionary and flawed. For example, the DSM-IV included loss of menstruation as a diagnostic criteria for anorexia nervosa, which automatically excludes individuals without a uterus or with other reasons for not menstruating. The update removing this criteria for an anorexia diagnosis was not included until the 2013 release of the DSM-V.

Due to exclusionary and highly specific diagnostic criteria, eating disorder diagnoses per the DSM-V are rare. However, many individuals struggle with pathological disordered eating, unhealthy weight control behaviors, and body dissatisfaction that can deeply affect health. These behaviors, referred to as “subthreshold disordered eating,” have similar health consequences to having a diagnosed eating disorder.^{11, 12} Although these health consequences are real and harmful, many patients are without adequate treatment options due to lack of insurance coverage and few treatment options overall. Thus, your role as a clinician is to promote positive eating and body image among all patients, regardless of their appearance or social background.

ADDITIONAL FACTS ABOUT DISORDERED EATING

- 9% of Americans (28.8 million people) will develop an ED in their lifetime.¹³
- BIPOC are less likely than white people to have been asked by a doctor about ED symptoms,¹⁴ but more likely to report struggling with disordered eating.¹⁵
- BIPOC with EDs are half as likely to be diagnosed or receive treatment.¹³
- Less than 6% of people with EDs are medically diagnosed as “underweight.”¹⁶
- Most people with EDs are “normal” weight, “overweight”, or “obese.”¹⁷
- LGBTQ people are disproportionately affected by disordered eating and eating disorders.^{18, 19}
- People with high levels of food insecurity are at high risk for disordered eating behaviors and eating disorders.²⁰
- Special populations, including military personnel, nurses, and registered dietitians are at high risk for disordered eating in part due to occupational demands.²¹⁻²³

BIOPSYCHOSOCIAL ASPECTS OF EDO



<https://www.nationaleatingdisorders.org/risk-factors>

Whitney Trotter

The above graphic on Biopsychosocial Aspects of EDO (or eating disorders) by Whitney Trotter shows that eating disorder risk is shaped by risk factors ranging from genetic to structural.

Funding for eating disorders research is a challenge for clinicians and scientists to advance our understanding of eating disorders. It is very hard to get funding for eating disorders research if your outcome is not ensuring people return to a BMI classification of "healthy weight" after recovering. Yet, over-emphasizing a "healthy weight" BMI as an outcome of eating disorders treatment can be counter to the goal of treatment: to restore a supportive relationship with food. As a result, the eating disorders literature for folks in larger bodies and with diverse identities is not as robust and contains its own biases. Current treatment options are also informed by this flawed literature. As a clinician, honoring your patient's report and lived experience with food is critical, and it is also important to recognize that existing treatment options may not be supportive for your patient's unique circumstances.


Signs of Disordered Eating²⁴

Weight loss is only one potential physical sign of an individual that is malnourished or experiencing a dysfunctional relationship with food. In fact, "atypical anorexia" - anorexia in an individual not categorized as underweight or in whom significant weight loss is not present - can present with all the same signs, symptoms and medical complications and is statistically more common.

Believe your higher weight patient if they report they are not eating.¹⁰

- Bradycardia
- Orthostatic hypotension
- Low body temperature/always being cold
- Osteopenia
- Menstrual cycle abnormalities (if menstrual status is shared and known and person is premenopausal)
- Thinning hair, nails
- Easily bruised or damaged skin
- Swollen facial glands
- GERD

Note: these complications can be present in any body size.



Signs of Disordered Eating (continued)

- Rapid weight change (loss or gain)
 - If client reports weight loss, do not assume it is healthy
- Inquire as to amount and time frame, usual body weight, and your patient's thoughts as to why the weight loss occurred.
- Weight gain after intentional weight loss efforts is extremely common. It is a normal response to restriction and the body's attempt of maintaining equilibrium. It is not a sign of "failure" on the part of the patient
- Observe for signs of hunger that are not weight-related or demonstrated by weight loss:²⁵
 - Dizziness, lightheadedness
 - Fatigue
 - Headache
 - Stomach pains/cramping
 - Shakiness/weakness
 - Thoughts about food
 - Mood disruptions

Additional psychological, social, and behavioral signs to watch out for:

- Irregular or infrequent mealtimes
- Sudden restrictions on types of foods eaten (e.g., elimination diets, sudden avoidance of nutrients and food groups, for example gluten, dairy, etc.)
- A sudden change in the frequency of exercise/movement, such as going from sedentary to a 30 day program, or suddenly stopping favorite physical activities
- Traumatizing events and sudden life changes, including loss of a loved one, relationship changes, job/occupational changes, housing changes, disruption of social services, etc.
- Psychological comorbidities, including anxiety, stress, depression, OCD, and poor sleep

WHILE EATING DISORDERS CAN CAUSE MULTIPLE MEDICAL COMPLICATIONS, THEY ARE PSYCHIATRIC DISORDERS. ANY MEDICAL SIGNS AND SYMPTOMS SHOULD BE FOLLOWED UP WITH QUESTIONS THAT ADDRESS THE PSYCHOLOGICAL AND SOCIOEMOTIONAL SYMPTOMS.

EATING DISORDERS & DISORDERED EATING

DISCUSSING DIET CHANGES, WEIGHT, AND BODY IMAGE WITH PATIENTS

It is well-established that physician-recommended diets and comments about weight can trigger disordered eating behaviors and body image concerns among patients, particularly pediatric patients.²⁶ As a physician, before you talk to your patient about food and their body, take time to reflect on your own relationship with food and body. Physicians and patients are exposed to the same mainstream messaging and misinformation about dieting and body image. Just because a diet (e.g., keto, intermittent fasting, etc.) “worked” for you or someone you know does not mean it will work for your patient. Further reflection questions about diet and body image are included under “Prompts for Reflection.”

In general, physicians should avoid recommending any food restriction to patients. Instead, focus on what your patient can add to their diet that might be supportive of their health.

- **Ask patients what their motivations are for changing their diet.** Some patients may be motivated to change their diet to change their weight. For some patients, changing weight is very important to them. Their lived experience might reflect difficult experiences from being at a higher weight (often those difficult experiences are attributable to larger social and structural problems). You can validate their challenges.
- **Ask permission before sharing your knowledge** about the risks of disordered eating from pursuing diet changes and that behavior is a small determinant of our weight, relative to genetic and structural factors.
- **Discuss your patient’s values** to understand what they hope to gain from diet changes. For example, if they do not feel they have enough energy or are concerned about fitness, discuss the benefits of eating regularly throughout the day. If they want to feel better to keep up with children or grandchildren, discuss the overall scope of health behaviors involved, including managing stress, getting enough sleep, and eating regularly, rather than characterizing diet changes as a fix-all.

EATING DISORDERS & DISORDERED EATING

DISCUSSING DIET CHANGES, WEIGHT, AND BODY IMAGE WITH PATIENTS

Many times, when people start a diet, they feel better because they are empowered to make a change over something- they feel they have control over something in their lives. Often, patients won't be concerned to make a dietary change that would concern a clinician. They are more likely to be focused on perceived benefits of changing their diet, rather than the costs, such as loss of social life, costs associated with changing food purchasing patterns, mental/emotional loss of energy by shifting focus to diet/body, and so forth. Providers might be concerned when recognizing those costs for their patient. This mismatch in patient/provider concerns is important to recognize when we consider the concept of patient centered care. If your patient is committed to making dietary changes that lean towards disordered eating, the best way you can support them is to remove judgment and come from a place of understanding about their perspective so they continue to view you as a resource and to prevent healthcare avoidance. More considerations about this topic are included under "Eating Disorder Harm Reduction."

Importantly, refer out to a registered dietitian when conversations begin to feel out of your scope of practice.

Physicians should not discuss weight or share BMI with patients as a primary marker of health. There may be medically necessary times to discuss weight, such as when a patient demonstrates a significant weight change or if it is a topic they wish to discuss. In any circumstance, asking your patient's permission to discuss weight and setting some initial boundaries before starting the conversation can be helpful. These boundaries include giving your patient permission to end the conversation at any time, or to discuss the topic of weight without the mention of specific numbers. If weight becomes relevant to the conversation, physicians should not avoid the topic of body image. Body image, including body dissatisfaction and attunement with one's body, is relevant to one's health. Physicians should take the time to consider their own body image- how has your role as a physician affected your view of your body? Although the topic of body image may be uncomfortable to you, recognize that every patient has a relationship and perception of their own body that affects how they pursue health. Let your patient know that how they feel about their body is important to you and you are there to listen and provide resources.

EATING DISORDERS & DISORDERED EATING

DISCUSSING DIET CHANGES, WEIGHT, AND BODY IMAGE WITH PATIENTS

When discussing weight or body, use neutral and descriptive terms, including

- Larger body, smaller body
- Higher weight, lower weight
- Typical or usual weight for an individual
- Avoid “excess,” “under,” “over,” “normal,” or “healthy,” which all imply there is a universal standard way to be.
- A patient may self-describe as fat. You can also use the word fat if there is permission and clarity between you and the patient that the term is being used as a neutral descriptor.
- If a patient asks how their weight is doing, avoid saying “good,” “bad,” “worse,” or “better.” Ask them about their motivations for asking. You can use other neutral words, like “up” or “down” to describe changes, if necessary.

Action items for clinicians:

1. Make the weight portion of a visit optional, or don't include it.
2. If weight is necessary for prescriptions or procedures, train medical staff to ask for permission before weighing clients and inquire if the client is interested in knowing their weight.
 - a. If a client/patient has requested not seeing weight/BMI, emphasize to medical staff the importance of hiding weight/BMI if they've written it on a chart, post-it, etc.
 - b. If BMI and weight cannot be removed from discharge/visit summaries that are shared with patient, ask staff to Sharpie/white out the numbers in all areas where they can be seen.
 - c. Advocate for the EMR to include the option for removing weight and BMI from patient portals and discharge/visit summaries.
 - d. Advocate for the EMR to include an area for patient preferences on how they would like the medical staff to discuss weight, BMI, and food.
3. Educate yourself on both the physiological and psychological manifestations of an eating disorder.
4. Challenge the assumption that an eating disorder has a recognizable “look.”

Most importantly, make screening for disordered eating a routine practice in your clinic.

EATING DISORDERS & DISORDERED EATING

DISORDERED EATING SCREENING

Building screeners or screening questions into intake forms is a critically important step to get the conversation about disordered eating and body image going in your clinic. Two options include using a short-form questionnaire, such as the SCOFF, or to integrate a couple screening questions yourself, such as: 27

- Have you ever been diagnosed with or do you suspect you have an eating disorder?
- Please describe your relationship with food and your body.
- On a scale of 0 to 10 with 0 being not at all and 10 being constantly, how often do you deal with thoughts of managing food and eating?
- On a scale of 0 to 10 with 0 being not at all and 10 being constantly, how often do you experience distress about your body image, body size, or weight?

Additional disordered eating screening tools include:

- **ARFID:** Nine Item ARFID Screen (NIAS)
 - ARFID is the avoidant restrictive food intake disorder, in which people have very little interest in food or are selectively picky eaters
- **BASE:** Brief Assessment of Stress and Eating (BASE)
- **EAT-26**
 - Validated but problematic (fatphobic, food shaming)
- **HAES screener**
 - Not validated, no scoring, not translated, (seemingly) stigma-free
- **PHQ-9**
 - Assesses for depression and anxiety, has one question related to eating

If a patient reports concerning answers to any of these methods, explore their responses with them. Refer patients to specialists and use other members of your team, including registered dietitians and social workers.


Screening questionnaires are not validated for populations across diverse racial and ethnic groups, cultural backgrounds, and may also perform differently for folks in different body sizes. This limitation is due to challenges in the eating disorders literature discussed above. Having a conversation or referring to a dietitian may be more informative.

EATING DISORDER HARM REDUCTION

What if my patient has an eating disorder and there's no treatment?

What if my patient does not want treatment? These two situations are exceedingly common for people struggling with disordered eating. The phrase “harm reduction” has become increasingly common in medical spaces, particularly as opioid-related harms have come to the forefront of media attention. Though frequently co-opted by public health spheres, harm reduction is rooted in the work of Black and indigenous communities that spans centuries. The phrase “liberatory harm reduction” has been described by Shira Hassan to honor the history and inextricable relationship of harm reduction with decolonization, abolition, and anticapitalism.²⁹ These practices are essential for BIPOC survival and include peer-to-peer care, grassroots organizing, information sharing, protection from police and other forms of violence, and much more. We acknowledge that the dominant eating disorder treatment model is deeply carceral, and that to provide anti-racist eating disorder care, we must abolish forced treatment. We are inspired by the work of Dr. Jennie Wang-Hall who envisioned abolitionist ED treatment as an alternative to forced treatment.

Self-determination and bodily autonomy are essential to any liberatory therapeutic relationship, and to building a justice-oriented future. For those who have trained in anti-fat, Western spaces, this may mean towing a line of discomfort with non-normative and biomedically “unhealthy” disordered eating behaviors. Accessible, specialized eating disorder treatment is rare, often not culturally tailored, and often not effective. There are tremendous barriers in addition to cost, time, and emotional labor due to the carceral nature of partial hospitalization and in-person treatment centers. We can recognize the multitude of reasons people have eating disorders and the multitude of ways they would like any intervention to unfold. As Gloria Lucas of Nalgona Positivity Pride describes in a conversation with Shira Hassan, “Pushing a ‘recovery-only’ approach is a self-gratifying practice to opt out of analyzing the factors that contribute to and exacerbate eating disorders in the first place—childhood adversity, food insecurity, historical/intergenerational trauma, racism, poverty, fatphobia, sexism, and more” (Saving Our Own Lives pg 256). Disordered eating can be an effective coping mechanism in response to one or more of these factors. Some people may desire significant behavior change, and others may want to continue disordered eating practices.



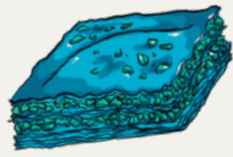
Eating disorder harm reduction aims to:

1. Acknowledge the forces of systemic oppression, including racism, that cause disparate experiences and may be relevant to the development of disordered eating practices.
2. Acknowledge that these forces are *not* an individual problem and therefore healing must integrate systemic change.
3. Acknowledge the carceral nature of eating disorder treatment and utilize an abolitionist perspective in treatment or non-treatment.
4. Provide people with disordered eating resources on risk reduction and healthcare maintenance, regardless of the degree of their engagement with dominant treatment modalities.

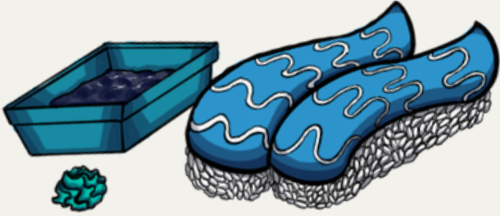
Practical tips on reducing risks of eating disorder practices include:²⁸

- Taking multivitamins such as B12, folate
- Taking medications at night, when less likely to purge
- Getting DEXA scans as appropriate
- Swishing a baking soda and water mixture after purging to prevent dental erosion
- Avoiding teeth brushing immediately after purging to prevent dental erosion
- Flossing frequently and using a tongue scraper
- Taking a probiotic to assist with digestive health
- Using heat packs to help with abdominal cramps
- Drinking lots of water

Thinking this way may require significant adjustment on the part of the clinician. Instead of focusing on recovery, the attention shifts to supporting and improving quality of life. Eating disorder harm reduction can include goals of care conversations, in which the patient explores what would improve their quality of life.³⁰⁻³³

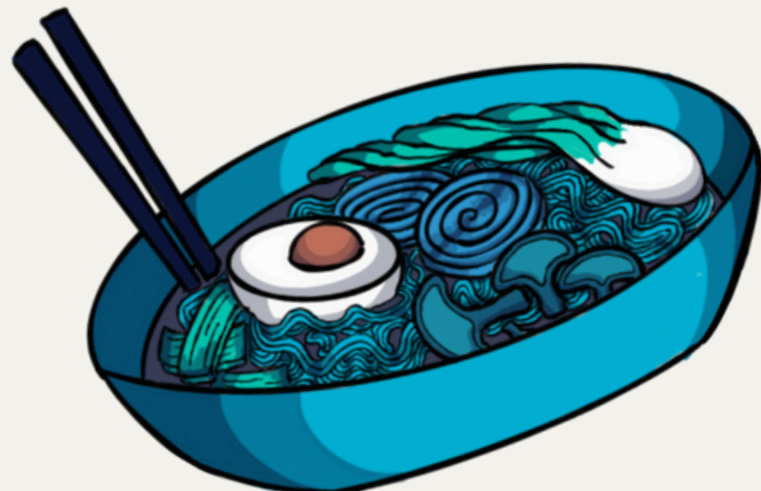


CONSIDERATIONS FOR SUPPORTING YOUR PATIENT THROUGH SELF-DIRECTED EATING



As mentioned in previous sections, there are tremendous misperceptions about what constitutes a “healthy” or “appropriate” diet. The first step in understanding whether your patient has a “healthy” diet is to explore what “healthy” means to you and to your patient. It is important to remember that “health” itself is a moralized term and the best diet for your patient might be the one that provides them the most autonomy and is self-led or self-directed. Things to consider when exploring what “healthy” means and what a self-directed diet could look like include:

- **Is there access to enough culturally appropriate food on a consistent basis?** Returning to the concept of food security and sufficiency, having enough adequate food consistently extends beyond financial resources. A patient missing lunch on a regular basis because their work schedule is too busy (a common situation for physicians, as well!) is one example of a time where food is not consistently available. It is worth referring patients in these scenarios to a registered dietitian because they can have downstream effects if left untreated for an extended period.
- **Are personal preferences, including for taste/flavor, texture, appearance, and timing accommodated?** Eating food you do not like is stressful, and no one deserves to have to eat food they do not prefer. This challenge could affect people relying on food shelves or food banks, or who live in areas where a variety of food is not easily accessible.
- **Is there respect for personal desires for health goals (or no health goals)?** Some patients may make food choices with their health in mind, and other patients may view food as something separate. Remember that pleasure and comfort from food can be health-supporting.

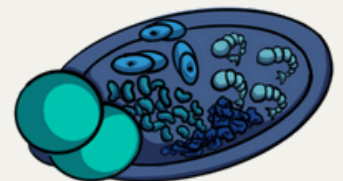




Additionally, food is an essential component of culture. Cultural practices and traditions are often handed down through food, how food is prepared, and how food is eaten. It is important to remember that any culture, racial or ethnic group, or religion is not a monolith. What is relevant to one's culture could vary by generation, geographic place, and individual characteristics. Do not make assumptions. If someone's cultural food preferences and practices are a priority to them, they should be a priority to you. Honoring cultural food practices is a significant way to support wellbeing. However, Western models and approaches to food, eating, and treatment of conditions (such as type 1 diabetes) are exclusionary of many cultures. For example, the United States Department of Agriculture's MyPlate does not fully honor the mixed dishes, cooked vegetables, spices, grains, community eating, and fasting practices characteristic of different cultural groups. You are unlikely to be able to advise on someone's cultural diet. Your role is to listen, learn, and support to ensure culture is honored.

As a physician, you will likely not have time to have detailed conversations about these topics. However, naming these concepts could be hugely helpful to a patient's autonomy to validate they do not need to ascribe to an external definition of "healthy." While not all of these factors can be perfectly achieved at all times, striving for a diet that satisfies is one step in ensuring that your patient is following a supportive, self-directed diet.

Some caveats on eating disorder screening and self-directed eating: some people may have difficulty listening to body cues, with interoceptive awareness, and characteristics such as neurodiversion or food aversions can add nuance to navigating eating disorder screening and self-directed diets. Physicians should always refer to a specialist when navigating these circumstances feels beyond their scope of practice.



Key Takeaways:

- **Food plays many essential roles** in our lives beyond providing nutrients.
- **Eating disorders affect everyone**, and your patient who does not fit the skinny, white, affluent girl stereotype might actually be at higher risk.
- **Believe your patient** when they reveal signs of struggling with having a healthy relationship with food and their body (regardless of size).
- **Screen** for disordered eating and food security.
- **Honor** the foods and eating patterns important to one's culture. Your goal is to support your patient's autonomy around food.
- **Reflect** on your own relationship with food, body, and your biases.

PROVIDER DO'S AND DON'TS

DON'T

- Make assumptions that what you consider to be “healthy” is what someone else considers to be healthy
 - Assume you know what is best for your patient when it comes to food and communicating in a paternalistic manner
 - Make assumptions about your patient’s cultural food practice
 - Feel like you need to know and/or provide the patient with information that is beyond your scope of practice
 - Make assumptions about someone’s food or nutrition knowledge
 - Shame your patient for their food choices, body size, or health status
-

DO

- Inquire (with permission) about the patient’s relationship with food and their body
- Ask for permission before sharing information about food
- Recognize if one has limited food and nutrition knowledge
- Share information in ways that aim to reduce harm
- Inquire about food access and security
- Admit when you have limited nutrition knowledge
- Refer out to a registered dietitian
- Advocate for creation of eating disorder-informed and culturally appropriate education materials by a paid consultant if your clinic does not have a registered dietitian
- Advocate for livable wages for registered dietitians and social workers

PROMPTS FOR REFLECTION

FOOD AND DIET

- What beliefs or perceptions did you have about a “healthy diet” before starting medical school? How has your medical education influenced your views about food? Do you find some foods to be villainized and other foods to be moralized as healthy?
- How have aspects of the medical school environment (e.g., competitiveness, neuroticism, requirements to work long hours) influenced your relationship with food?
 - Do you have time to cook? Are you relying on snack foods to study long hours? Are you relying on quick convenience foods due to time constraints and availability? Do you miss meals because of medical school requirements?
- How has your time in medical school influenced your community? For example, do you find yourself surrounded by primarily white people with Western diets? Do you find yourself primarily around people with consistent, reliable food access? Do you find yourself around people who have never struggled with food security?
- How does your role as a medical student and future doctor relate to emotions you have about your food choices? (E.g. guilt, shame, moral superiority, etc.)

PROMPTS FOR REFLECTION

BODY IMAGE

- What changes have you noticed in your body throughout your medical school journey? How have medical school requirements (e.g., needing to be sedentary for long hours to study, stress, lack of sleep) affected your body? How has your relationship with your body changed?
- How has your medical school education affected your perception of your body?
- What comes up for you, personally, when considering your weight and BMI when these topics are discussed in a medical setting?
- How does your role as a medical provider affect your feelings about your body?
- How do you feel your body affects how others perceive you in your professional role as a medical provider?

BROADLY

- How are these aspects of the medical school environment detrimental to health and contributing to maladaptive eating and weight control behaviors?
- How can you support your peers to pursue health-promoting behaviors in spite of medical school requirements?
- How can you advocate for change in your medical school community to better support the health of other medical students?

PATIENT *Resources*



NALGONA POSITIVITY PRIDE

<https://www.nalgonapositivitypride.com/>

Nalgona Positivity Pride (NPP) is an unconventional eating disorder awareness organization that shines a light on the often-overlooked societal factors that perpetuate unrealistic and oppressive beauty and health standards. NPP offers a vital space for BIPOC individuals to celebrate and embrace their bodies and identities.



THE BLACK NUTRITIONIST

<https://www.blacknutritionist.com>

Dr. Kera is a nutrition expert, food activist and nutrition coach empowering Black women with the know-how to better nurture their bodies by letting go of food guilt and shame. She is the creator of the coaching program “Decolonize Your Plate.”

OLDWAYS TRADITIONAL DIETS

<https://oldwayspt.org/traditional-diets>

This is a non-profit dedicated to improving public health by inspiring individuals and organizations to embrace the healthy, sustainable joys of the “old ways” of eating—heritage-based diets high in taste, nourishment, sustainability, and joy. Since 1990, they’ve helped people live healthier, happier lives by offering educational programs, resources, and recipes based on shared cultural food traditions from around the world. It’s a mission they take great joy in, one with proven nutritional and emotional benefits.

PATIENT *Resources*

ASSOCIATION FOR SIZE DIVERSITY AND HEALTH (ASDAH)

<https://asdah.org/>

As a non-profit organization with an international membership committed to the practice of the Health At Every Size® (HAES) Principles, ASDAH envisions a world that celebrates bodies of all shapes and sizes, in which body weight is no longer a source of discrimination and where oppressed communities have equal access to the resources and practices that support health and well being.



SICK ENOUGH: A GUIDE TO THE MEDICAL COMPLICATIONS

Jennifer L. Gaudiani

Taylor & Francis, 14 sept. 2018 - 276 pages

Patients with eating disorders frequently feel that they aren't "sick enough" to merit treatment, despite medical problems that are both measurable and unmeasurable. They may struggle to accept rest, nutrition, and a team to help them move towards recovery. Sick Enough offers patients, their families, and clinicians a comprehensive, accessible review of the medical issues that arise from eating disorders by bringing relatable case presentations and a scientifically sound, engaging style to the topic. Using metaphor and patient-centered language, Dr. Gaudiani aims to improve medical diagnosis and treatment, motivate recovery, and validate the lived experiences of individuals of all body shapes and sizes, while firmly rejecting dieting culture.



HEARTSPACE PEER SUPPORT

<https://beam.community/programs/peer-support-spaces/>

A monthly, online and in-person support group for Black folks. Heart Space focuses on healing and wellness and also provides resources to Black health care providers to prioritize their own self-care.

DECISION TREE FOR NUTRITION GUIDANCE IN NON-RDS

BY: CAROLINA (CAROL) GUIZAR

Decision Tree for Nutrition Guidance in Non-RDs

This document was created for individual patient care only and is not a standardized diagnostic tool. Please seek written permission from Carolina Guizar, MS, RDN, CDN (hello@eauthority.com) if you wish to use this in any other context (educational purposes, trainings, etc).



Before giving specific nutrition guidance around prevention or management of chronic condition, ask the following:

Do you have a history of chronic dieting or an eating disorder, including ARFID?

•Definition of Flexibly*

- Nutrition goal does not become a rule that must be followed
- Does not feel guilty, shameful or worried if meals do not meet food goals

Are you actively struggling with disordered eating?

Are you food secure?

- Referral to therapist for further assessment, disordered eating registered dietitian (RD)
- Acknowledge provider hesitation to provide information that may further complicate patient's difficult relationship with food
- Encourage adequacy and consistency and other accessible self-care behaviors that may impact client's chronic condition
- Provide handout on ED resources
- Reference SBIRT provider scripts for communication guidance

Do you have a desire to explore food interventions?

- Emphasize importance of eating for adequacy and consistency (especially if blood sugars are concern)
- Choosing food based on what is accessible
 - Beans, rice, canned foods, frozen food
- Focus on medication(s) for chronic condition management and other accessible self-care strategies

Can you use nutrition information flexibly*?

Refer to RD and provide basic diet education including:

- Encourage adequacy, consistency, balance (protein, fat, starch, fruit/vegetables)
- Provide basic nutrition recommendations related to client's chronic condition(s) using affirmative language
- Use medications as desired/necessary for chronic condition management
- Encourage other accessible self-care strategies
- Dietary changes can be experimental
- **Reminder:** food interventions are trials and may not always have desired health effects

- Use motivational interviewing to understand ambivalence
 - What concerns do you have?
- Can trial as many or as little changes as feels accessible
- Can trial strategies from YES and NO subcategories in "Can you use nutrition info flexibly?" as desired

Encourage:

- Adequacy and consistency in eating
- Eating foods that feel accessible and enjoyable to patient
- Accessible/desired self-care behaviors

Use harm reduction strategies throughout:

- Do no prescribe weight loss as intervention
- Change language to more affirmative wording
 - High/low/normal → out of range/above range/below range, within range
 - Good/bad/healthy/unhealthy → accurate and neutral description of food, e.g., fruits, vegetables, sweet/sugary foods, protein-rich, energy-rich
- Transition from prescriptive to suggestive language
 - Try this/that → May/Could be helpful to try X...Does that seem like something you want to try?
- Communicate that health is multifaceted
- **Reminder:** Decisions to pursue nutrition interventions is decided by patient

FULL GUIDE BELOW



SOURCES

1. Matheson EM, King DE, Everett CJ. Healthy lifestyle habits and mortality in overweight and obese individuals. *J Am Board Fam Med.* 2012;25(1):9-15. doi:10.3122/jabfm.2012.01.110164
2. Neumann, Melanie, et al. "Why context matters when changing the diet: A narrative review of placebo, nocebo, and psychosocial context effects and implications for outcome research and nutrition counselling." *Frontiers in Nutrition* 9 (2022): 937065.
3. Lipshutz, Judith A., et al. "Leveraging social and structural determinants of health at the centers for disease control and prevention: a systems-level opportunity to improve public health." *Journal of Public Health Management and Practice* 28.2 (2022): E380-E389.
4. Chang Y, Chatterjee S. Housing instability, food insecurity, and barriers to healthy eating. *Family and Consumer Sciences Research Journal.* 2022;51(1):51-64.
5. Coleman-Jensen, Alisha, Matthew P. Rabbitt, Christian A. Gregory, and Anita Singh. "Household food security in the United States in 2018." (2019).
6. Sonnevile KR, Lipson SK. Disparities in eating disorder diagnosis and treatment according to weight status, race/ethnicity, socioeconomic background, and sex among college students. *Int J Eat Disorder.* 2018;51(6):518-526. doi:<https://doi.org/10.1002/eat.22846>
7. Harrop, Erin N. "Typical-atypical interactions: One patient's experience of weight bias in an inpatient eating disorder treatment setting." *Women & Therapy* 42.1-2 (2019): 45-58.
8. Burnette, C. Blair, Jessica L. Luzier, Chantel M. Weisenmuller, and Rachel L. Boutté. "A systematic review of sociodemographic reporting and representation in eating disorder psychotherapy treatment trials in the United States." *International Journal of Eating Disorders* 55, no. 4 (2022): 423-454.
9. Weissman, Ruth Striegel. "The role of sociocultural factors in the etiology of eating disorders." *Psychiatric Clinics* 42.1 (2019): 121-144.
10. Harrop, Erin N., et al. "Restrictive eating disorders in higher weight persons: A systematic review of atypical anorexia nervosa prevalence and consecutive admission literature." *International Journal of Eating Disorders* 54.8 (2021): 1328-1357.
11. Crow, Scott J., W. Stewart Agras, Katherine Halmi, James E. Mitchell, and Helena C. Kraemer. "Full syndromal versus subthreshold anorexia nervosa, bulimia nervosa, and binge eating disorder: A multicenter study." *International Journal of Eating Disorders* 32, no. 3 (2002): 309-318.
12. Stice, Eric, C. Nathan Marti, Heather Shaw, and Maryanne Jaconis. "An 8-year longitudinal study of the natural history of threshold, subthreshold, and partial eating disorders from a community sample of adolescents." *Journal of abnormal psychology* 118, no. 3 (2009): 587.
13. Deloitte Access Economics. *The Social and Economic Cost of Eating Disorders in the United States of America: A Report for the Strategic Training Initiative for the Prevention of Eating Disorders and the Academy for Eating Disorders.* Accessed on October 1, 2023. <https://www.hsph.harvard.edu/striped/report-economic-costs-of-eating-disorders/>
14. Becker AE, Franko DL, Speck A, Herzog DB. Ethnicity and differential access to care for eating disorder symptoms. *Int J Eat Disord.* 2003;33(2):205-212.
15. Simone, Melissa, Susan Telke, Lisa M. Anderson, Marla Eisenberg, and Dianne Neumark-Sztainer. "Ethnic/racial and gender differences in disordered eating behavior prevalence trajectories among women and men from adolescence into adulthood." *Social Science & Medicine* 294 (2022): 114720.
16. Flament M., Henderson K., Buchholz A, et al. Weight Status and DSM-5 Diagnoses of Eating Disorders in Adolescents From the Community. *J Am Acad Child Adolesc Psychiatry.* 2015;54(5):403-411

SOURCES

17. Nagata, Jason M., Andrea K. Garber, Jennifer L. Tabler, Stuart B. Murray, and Kirsten Bibbins-Domingo. "Prevalence and correlates of disordered eating behaviors among young adults with overweight or obesity." *Journal of General Internal Medicine* 33 (2018): 1337-1343.
18. Parker, Lacie L., and Jennifer A. Harriger. "Eating disorders and disordered eating behaviors in the LGBT population: a review of the literature." *Journal of Eating Disorders* 8 (2020): 1-20.
19. Harrop, E.N.; Hecht, H.K.; Harner, V.; Call, J.; Holloway, B.T. "How Do I Exist in This Body...That's Outside of the Norm?" *Trans and Nonbinary Experiences of Conformity, Coping, and Connection in Atypical Anorexia*. *Int. J. Environ. Res. Public Health* 2023, 20, 1156. <https://doi.org/10.3390/ijerph20021156>
20. Becker CB, Middlemass K, Taylor B, Johnson C, Gomez F. Food insecurity and eating disorder pathology. *Int J Eat Disord*. 2017;50(9):1031-1040.
21. Mitchell, K. S., B. Porter, E. J. Boyko, and A. E. Field. "Longitudinal associations among posttraumatic stress disorder, disordered eating, and weight gain in military men and women." *American journal of epidemiology* 184, no. 1(2016): 33-47.
22. Ku, Bertha, Kathryn E. Phillips, and Joyce J. Fitzpatrick. "The relationship of body mass index (BMI) to job performance, absenteeism and risk of eating disorder among hospital-based nurses." *Applied Nursing Research* 49 (2019): 77-79.
23. Tremelling, Kaylee, Lona Sandon, Gloria L. Vega, and Carrie J. McAdams. "Orthorexia nervosa and eating disorder symptoms in registered dietitian nutritionists in the United States." *Journal of the Academy of Nutrition and Dietetics* 117, no. 10 (2017): 1612-1617.
24. Eating Disorders. National Institutes of Health. Accessed 10/7/2024, <https://www.nimh.nih.gov/health/topics/eating-disorders>
25. Valdez, R. "Hunger." *VeryWell Health*. November 22, 2022., <https://www.verywellhealth.com/hunger-6265658#:~:text=Hunger%20is%20a%20physiological%20sensation,Feel%20Full%2C%20Backed%20by%20Science>
26. Harrop, Erin Nicole. "Maybe I Really Am Too Fat to Have an Eating Disorder": A Mixed Methods Study of Weight Stigma and Healthcare Experiences in a Diverse Sample of Patients with Atypical Anorexia. University of Washington, 2020.
27. Morgan JF, Reid F, Lacey JH. The SCOFF questionnaire: a new screening tool for eating disorders. *West J Med*. 2000;172(3):164-165. doi:10.1136/ewjm.172.3.164
28. Harm Reduction in Eating Disorders. January 3, 2021, <https://www.joyproject.org/harm-reduction-in-eating-disorders/>
29. Hassan, Shira. *Saving our own lives: a liberatory practice of harm reduction*. Haymarket Books, 2022.
30. Janse van Rensburg, M. COVID19, the pandemic which may exemplify a need for harm-reduction approaches to eating disorders: a reflection from a person living with an eating disorder. *J Eat Disord* 8, 26 (2020). <https://doi.org/10.1186/s40337-020-00306-3>
31. Andria Bianchi, Katherine Stanley & Kalam Sutandar (2021) The Ethical Defensibility of Harm Reduction and Eating Disorders, *The American Journal of Bioethics*, 21:7, 46-56, DOI: 10.1080/15265161.2020.1863509
32. WESTMORELAND, PATRICIA MD; MEHLER, PHILLIP S. MD. Caring for Patients With Severe and Enduring Eating Disorders (SEED): Certification, Harm Reduction, Palliative Care, and the Question of Futility. *Journal of Psychiatric Practice* 22(4):p 313-320, July 2016. | DOI: 10.1097/PRA.0000000000000160
33. Lucas, G., "Unleashing the Power of An Autonomous Eating Disorder Health Movement: The Eating Disorder Harm Reduction Manifesto" *Nalgona Positivity Pride*. June 2024, <https://www.nalgonapositivitypride.com/npp-blog/eatingdisorderharmreductionmanifesto>

CHAPTER FIVE:

Joyful Movement



After tying in everything that we've learned about weight, we wanted to conclude with this short section on re-imagining fitness in the medical industry. Our aim is to focus less on what's wrong with patients and more on what's happened to them and their own strengths by using four different mental paradigm shifts.

WHAT WE CURRENTLY THINK

Although there is an acknowledgement of how fitness promotes mental wellness, the focus of fitness is mainly for weight loss purposes

There are certain types of "best" exercises and they oftentimes solely rely on cardio

Promoting fitness without acknowledging barriers and restrictions that may prevent patients from engaging in exercise

Assuming that health professionals know more about fitness than they actually do

HOW TO MOVE FORWARD

Promote more **performance-based and mental wellness-based outcomes** over weight focused goals. Fitness has been shown to reduce anxiety, depression, negative mood, improve self esteem, and increase cognitive function.¹

Even small amounts of exercise like 10 minutes a day is better than none.² By shifting the focus to performance and smaller goals instead of weight loss, fitness goals can be more sustainable and attainable.

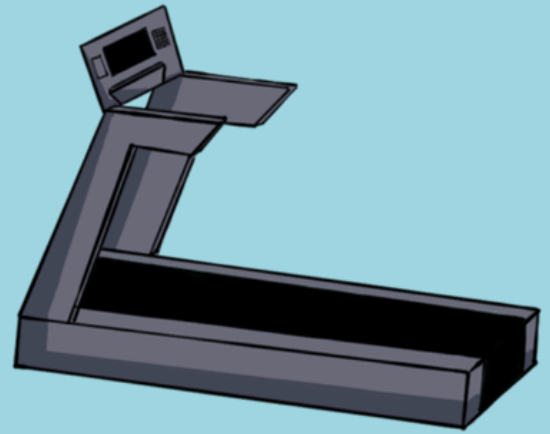
Although cardio shows plenty of evidence of being useful, the best type of exercise is the one that fits **patients' needs and desires**. When fitness is more enjoyable, there is often increased engagement, which can also lead to improved health and wellbeing.³

Therefore, if the goal is to increase physical activity engagement, fitness recommendations should be made in a way that is more fun to the patient and fits their lifestyle.

Acknowledge social factors like neighborhood safety, lack of access to the gym, etc. when advising fitness. Those who are more advantaged are more likely to engage in fitness, so it's important to address and recognize why someone may or may not be able to engage in certain fitness regimens before making recommendations.⁴

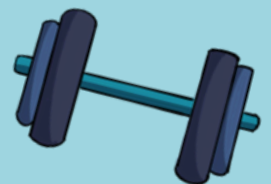
Refer to coaches and certified personal trainers for detailed instructions on fitness. One study has shown that only one-fifth of physicians would refer their patients to a personal trainer, even though physical trainers and health clubs are shown to be traditional outlets for promoting physical activity and exercise regimens.⁵

Therefore, there is a need for more physicians to partner with physical trainers in order to provide exercise regimens to patients, while also recognizing that personal trainers may carry unaddressed weight bias.⁶



Key Takeaways:

- Encouraging fitness from a **performance-based** lens instead of an aesthetic and weight-based lens can make it sustainable in the long term
- Take into account socioeconomic and environmental factors that may be barriers to fitness
- Focus more on movement that is enjoyable and small steps--10 minutes a day may be more attainable than an hour
- Outsource to certified personal trainers when fitness knowledge is limited



SOURCES

1. Sharma, A., Madaan, V. and Petty, F.D., 2006. Exercise for mental health. Primary care companion to the Journal of clinical psychiatry, 8(2), p.106.
2. Jakicic, J. M., Kraus, W. E., Powell, K. E., Campbell, W. W., Janz, K. F., Troiano, R. P., ... & 2018 Physical Activity Guidelines Advisory Committee. (2019). Association between bout duration of physical activity and health: systematic review. Medicine and science in sports and exercise, 51(6), 1213.
3. Lakicevic, N., Gentile, A., Mehrabi, S., Cassar, S., Parker, K., Roklicer, R., ... & Drid, P. (2020). Make fitness fun: could novelty be the key determinant for physical activity adherence?. Frontiers in psychology, 11, 577522.
4. Ball, K., Carver, A., Downing, K., Jackson, M., & O'Rourke, K. (2015). Addressing the social determinants of inequities in physical activity and sedentary behaviours. Health promotion international, 30(suppl_2), ii8-ii19.
5. Pojednic, R., Bantham, A., Arnstein, F., Kennedy, M. A., & Phillips, E. (2018). Bridging the gap between clinicians and fitness professionals: a challenge to implementing exercise as medicine. BMJ Open Sport & Exercise Medicine, 4(1), e000369.
6. Fontana, F., Bopes, J., Bendixen, S., Speed, T., George, M., & Mack, M. (2018). Discrimination against obese exercise clients: an experimental study of personal trainers. International Journal of Exercise Science, 11(5), 116.

THANK YOU

Dear Reader,

We, the writers and editors of this guide, would like to take a moment to thank you for making the time to read some, or all, of our work. This was truly a labor of love, with countless hours of thought and effort poured into its creation. We hope you learned more about what it means to be weight inclusive in an increasingly biased world. This is by no means an exhaustive guide, and our understanding of weight, nutrition, and health is ever-evolving. We hope yours is, too, and we hope we played some small part in that evolution.

On the next page, we have included a few recommendations to help provide you with further information or to find community. We have included resources from fat positive creators, nutritionists, and activists across a number of modalities.

Keep learning.

Love,

Weight Inclusive Healthcare Initiative

Weight Inclusive Healthcare Initiative

WANT TO LEARN MORE?

INSTAGRAM

@thenutritiontea
@dietitiananna
@bodypositive_dietitian
@whitneytrotter.rd
@rds_for_neurodiversity
@thethicknutritionist
@your.latina.nutritionist
@drcolleenreichmann
@blackandembodied
@recoverwithmeda
@fattymph
@thefoodsystemsnutritionist
@drjoshuawolrich
@drlesleyw
@plussizetransguy
@ragenchastain
@the_bodylib_advocate
@bodyimage_therapist
@yrfatfriend

PODCASTS

Maintenance Phase hosted by Aubrey Gordon and Michael Hobbs

Burnt Toast hosted by Virginia Sole-Smith

Food Psych hosted by Christy Harrison
Rethinking Wellness hosted by Christy Harrison

Unsolicited: Fatties Talk Back hosted by Marquisele Mercedes, Da'Shaun Harrison, Caleb Luna, Bryan Guffey, and Jordan Underwood

BOOKS

Fat Activism: A Radical Social Movement by Charlotte Cooper, PhD

Fat Talk: Parenting In the Age of Diet Culture by Virginia Sole-Smith

What We Don't Talk About When We Talk About Fat by Aubrey Gordon

"You Just Need to Lose Weight" and 19 Other Myths About Fat People by Aubrey Gordon (2023)

Fat Gay Men: Girth, Mirth, and the Politics of Stigma (Intersections, 1) by Jason Whitesel

Belly of the Beast by Da'Shaun Harrison

Fearing the Black Body by Sabrina Strings

It's Always Been Ours: Rewriting the Story of Black Women's Bodies by Jessica Wilson, MS, RD

Fat Girls in Black Bodies by Joy Arlene Cox, PhD

Anti-Diet by Christy Harrison

The Body Is Not an Apology: The Power of Radical Self Love by Sonya Renee Taylor

