Recognizing and eliminating bias in those with elevated body mass index in women's health care

> My worst healthcare experience was with a new OB/GYN at my appointment to confirm my first pregnancy. I was elated and couldn't wait to have the doctor congratulate me, but instead she told me that I was a detriment to my unborn child because I was going to be an overweight mother, and that my baby deserved better. I left the office crushed and heartbroken. If I hadn't needed to seek medical treatment to ensure a healthy pregnancy, I would have never returned. I requested a new doctor and filed a complaint with the hospital, but I never heard anything back from them.
>
> – Rudd Center, personal communication

Obesity is one of the most common chronic conditions in the U.S. and globally. Worldwide, over 600 million adults can be classified as obese and according to the National Health and Nutrition Examination Survey, nearly 38% of U.S. adults have been classified as obese, and nearly 6% as class III obesity (body mass index [BMI] ≥ 40 kg/m^2) (1).

It is well established that obesity increases the risk of adverse health outcomes including hypertension, dyslipidemia, coronary heart disease, stroke, type 2 diabetes, gallbladder disease, sleep apnea, osteoarthritis, cancer, mental illness, and all-cause mortality (2). Compared to women with a healthy BMI, women with obesity are at increased risk of estrogen-mediated cancers, polycystic ovarian syndrome, birth defects, miscarriages, and impaired fertility (2). With respect to the field of reproductive endocrinology and infertility, women with obesity face lower live-birth rates following natural and assisted reproduction conception due to a combination of decreased pregnancy and implantation rates, as well as increased rates of miscarriage and pregnancy complications.

Elements that influence the amount of energy stored in the body, and therefore the risk of obesity, include biological and medical, psychological, social, environmental, dietary, economic, and developmental (including in utereo exposures) factors. Research supports such varied influencers as genetics, stress, infection, social anxiety, low socioeconomic status, sleep deficit, environmental toxins, and weight gain-inducing drugs (2). Despite the multitude of contributing components, the prevailing presumption in our society is that body weight is a matter of self-discipline and concerted efforts toward healthy eating and physical activity. As a result, people with obesity face bias and stigma in multiple settings including interpersonal relationships, health care, education, employment, and media. This stigma itself contributes to the pathophysiologic contributors to obesity (2, 3).

Patients have reported that the health care sector is one of the top sources of weight bias. Lack of health care provider support and knowledge contributes to patient stigma which further impacts this chronic disease. Studies of health care professionals including physicians, nurses, psychologists, dietitians, fitness professionals, and medical students from around the world suggest we view obese patients as awkward, unattractive, ugly, and noncompliant; weak-willed, sloppy, and lazy; stupid, and worthless; as well as self-indulgent; and that patients with obesity are commonly the target of derogatory humor, especially in surgery and OB/GYN settings (3). Futhermore, many providers believe that the lack of patient motivation and willpower are the cause of obesity, and that patients are to blame for their obesity. Studies also suggest that we feel unqualified to treat obesity and/or that obesity treatment is futile and we spend less time with obese patients compared to those with a normal BMI. It has been reported that more than half of patients with obesity are recipients of disrespectful or inappropriate comments from physicians. In fact, overweight and obese adults report that physicians are the second most frequent source of experienced stigma, following family members (3). Experiences of anti-fat bias in the medical field have been shown to lead to delays in seeking care, appointment cancellations, unhealthy eating habits including both binge eating and restrictive eating, and depression and low self-esteem due to perceived disrespectful treatment and embarrassment (3).

Obesity has been shown to negatively affect a physician's listening practices and time spent with the patient. Studies suggest that while 100% of OB/GYNs and family practioners felt that discussing gestational weight gain with obese women was important, 68% found the discussion unpleasant, 31% admitted to making derogatory statements to their obese patients, and 92% agreed that their communication skills needed improvement (4). Furthermore, individuals with obesity are significantly less likely to undergo routine gynecological exams, routine Papanicolaou tests, breast exams, and mammograms (5). The barriers often cited by women included not only provider attitudes and increased discomfort during exam, but physical barriers, including inappropriately sized equipment, gowns, vaginal speculums, examamination tables, and undersized waiting room chairs (5).

In our line of work, appropriate medical care of overweight and obese women is paticularly vital due to increased obstetrical and gynecologic risks associated with excess weight. As an REI, we have the opportunity to provide preconception counseling that emphasizes the adverse health effects and advocates that women aim to enter pregnancy with a healthy BMI to improve fertility and antepartum outcomes. Often, this requires a referral network of providers who are trained to help patiens access the tools available for weight management including diet, physical activity, psychological/social, medical, and surgical approaches.

> It's all in the Delivery
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> –Conan O'Brien

The pathology of obesity is complex and multifactorial. When addressing this disease with patients, it is imperative

for us to better practice the art of communication, become better listeners, and avoid being disingenuous and patronizing to those with excess weight. The use of sensitive language when referring to weight is important as this can significantly impact the patient experience, thus enabling a better patient-provider interaction that will allow a relationship of mutual respect and understanding.

Obesity is the most common chronic disease. Unfortunately, anti-obese attitudes and discrimination are prevalent in all medical fields, especially ours that specialize in women's health and infertility. This discrimination leads to delayed and suboptimal health care. As facilitors of conception, it is imperative that we take notice of the potential for obesity bias in our practice and take steps to eliminate it. This can be accomplished by increasing awareness through sensitivity training in medical education/staff training, emphasizing the importance of strong communication skills, and ensuring welcoming and inclusive medical facilities. All of these efforts can have a huge impact on women's health care.

> One of my worst experiences as an overweight person was to have a doctor refuse to do a gynecological exam because of my size. First, I cried. Then I found a new clinic and a new doctor. But since then I have not had the courage to go to a doctor to have that type of exam done.
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> –Rudd Center, patient reports of weight bias

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REFERENCES

1. Ogden CL, Carroll MD, Kit BK, Flegal KM. Prevalence of childhood and adult obesity in the United States, 2011-2012. JAMA 2014;311:806–14.
2. Obesity Society. Research. Education. Action. Available at: www.obesity.org/home. Accessed January 23, 2018.
3. Puhl RM, Heuer CA. The stigma of obesity: a review and update. Obesity (Silver Spring) 2009;17:941–64.
4. Grohmann B, Brazeau-Gravelle P, Momoli F, Moreau K, Zhang T, Keely E. Obstetric health-care providers' perceptions of communicating gestational weight gain recommendations to overweight/obese women. Obstet Med 2012;5:161–5.
5. Friedman AM, Hemler JR, Rossetti E, Clemow LP, Ferrante JM. Obese women's barriers to mammograph and Pap smear: the possible role of personality. Obesity (Silver Spring) 2012;20:1611–7.