Health at Every Size Principles: Clinician Perspectives To Limit Weight Stigma in Medical Care

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ABSTRACT

Objective: Health At Every Size is a paradigm that encourages body acceptance, intuitive eating, and other principles to increase healthy, peaceful living. The model is accepted by many in the mental health field, but in order for its principles to become standard in clinical (medical) care, clinician perspectives on Health at Every Size should be sought and understood.

Methods: Ten clinicians were interviewed (4 physicians, 2 nurse practitioners, and 4 physician assistants). Participants reviewed the HAES principles, and identified facilitators and barriers to respectful, weight-inclusive care.

Results: Most clinicians felt that body mass index is a useful, standard metric, but it is inadequate and can be a cause of distress. Providing non–weight-focused care was identified as the primary facilitator to respectful care.

Discussion: Participants viewed body mass index as useful in some scenarios but do not think it encompass a patient's well-being and has the potential to cause the patient distress (eg, perpetuating weight stigma). Barriers to using Health At Every Size in clinical practice included the need for clinician education, bias/stigma, and a focus on weight.

BACKGROUND

Weight stigma (or weight-based discrimination) is discrimination or stereotyping based on an individual's body weight, shape, or size.[1] Regardless of stigma being subconscious or overt, it has a negative effect on health and well-being. A 2018 systematic review revealed weight stigma to be positively associated with a variety of poor health outcomes, including obesity, diabetes risk, stress levels, depression, anxiety, and low self-esteem.[2] A plethora of research shows that elevated body weight is associated with myriad chronic health conditions, but the causality of the relationship between weight and health concerns is tenuous.[2]

The Health at Every Size (HAES) principles were developed in 2003 as a guide for a new organization called the Association for Size Diversity and Health, utilizing existing work by body size/weight researchers. HAES, a movement and approach to healthy living pioneered by several researchers, is a nontraditional approach to health and well-being that encourages people to honor their hunger and fullness cues (intuitive eating); eat a varied, unrestricted diet; and engage in joyful movement for health promotion instead of emphasizing weight loss. A HAES approach, implemented in small groups, has been shown to have long-term beneficial effects on eating behaviors (decreases in emotional eating, greater reliance on internal hunger cues), intuitive eating,[3-5] and body satisfaction.[4]

Several studies have investigated a HAES approach to health care and its effect on patients, but little research exists looking at clinicians' perceptions about the approach outside the mental health field. An important first step in shifting the paradigm from traditional medical advice of weight loss to a HAES approach is to understand the attitudes of health care professionals towards these principles.

METHODS

A 10-item semistructured interview guide (see Appendix) was developed. Each question was framed on the first three HAES principles: weight inclusivity, health enhancement, and respect ful care. Clinicians were recruited using two primary methods: social

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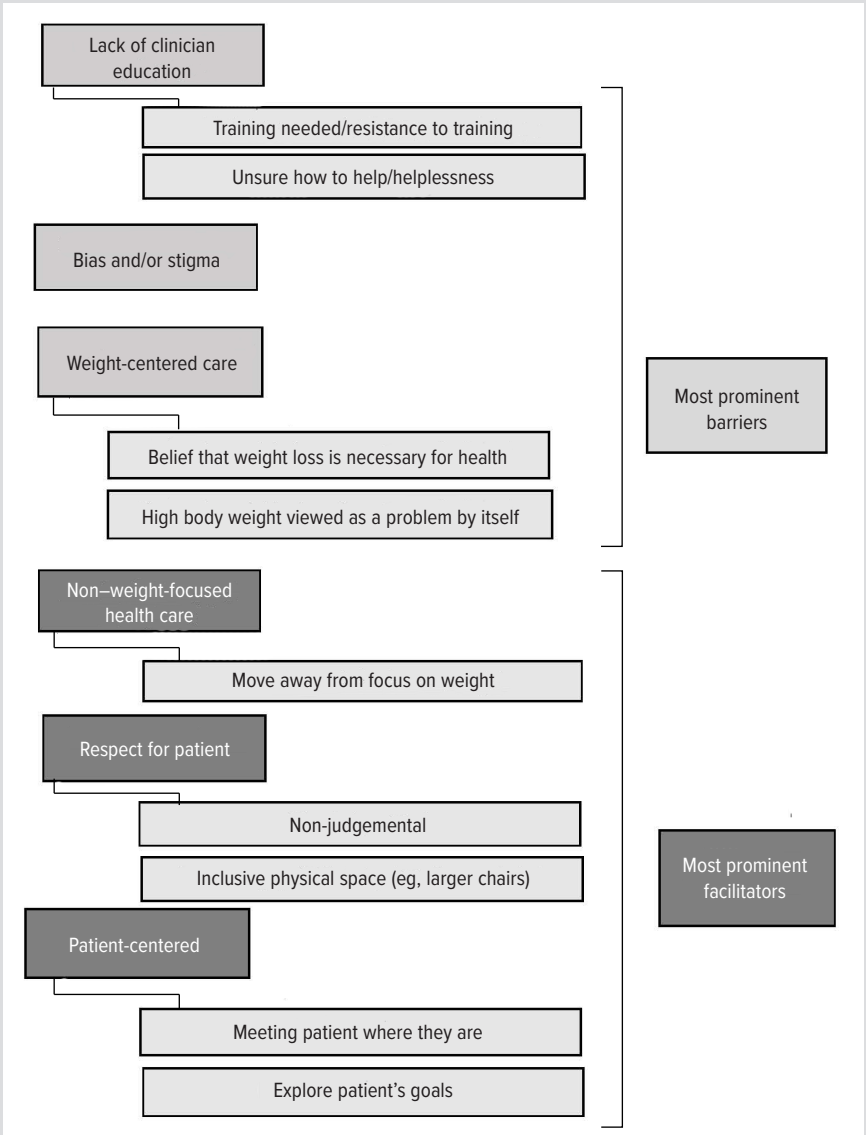
Table. Clinician Interview Responses

Quote	Theme
"I know some people, like, based on insurance…they don't go to the doctor because they're considered overweight."	BMI measure as a cause of patient distress Stops patients from visiting their doctor
"Especially since I have had patients that have gone through, like, anorexia nervosa and like diagnoses like that. And when I asked this specific patient, just like, when it all started and what she thought about that, she said that it was at her pediatrics office, when they were talking to her about her having a really high BMI."	BMI measure as a cause of patient distress Stops patients from visiting their doctor
"I wouldn't say that we would be weight blind, but I guess I'd say that we would be–you know, it's not like saying that we're going to be entirely color blind. It would be a move away from the focus on that."	Provide non–weight-focused care
"And kind of just knowing that that all bodies are different and genetics, and certain things all play a role."	Patient centered-care Respect for patient
"…I think again it's sort of an issue of education looking at the literature of what really improves life, not just improves BMI."	Clinician education needed
"…providers can have these notions that their weight is the only way to fix things when perhaps the patient is fine with their weight and fine with their body and how they feel."	Focus on weight-based care Weight is not a "problem to be solved"

Abbreviation: BMI, body mass index.

Figure. Barriers and Facilitators to Providing Respectful, Weight-Inclusive Care



media recruitment through a study poster (posted on Facebook) and an email blast to clinicians in the University of Wisconsin Family Medicine and UW Health clinician email list (convenience sample). The interviews took place using a secure, university-approved Webex virtual meeting room and were recorded for transcription purposes. Interviews typically took about 30 minutes. After the interview, the transcriptions were coded independently for categories and themes by two investigators using a content analysis strategy. Transcribed interviews were not returned to participants for notes/comments.

Three major findings from the interviews included clinician perspective on the body mass index (BMI) measure and both barriers and facilitators to respectful, weight-inclusive care.

RESULTS

Demographic information beyond job title was not collected for this pilot study. The sample of clinicians included 4 physicians, 4 physician assistants (including 1 student), and 2 nurse practitioners. Interviews were transcribed and coded by 2 independent researchers (SH, MH), who completed a qualitative thematic analysis. Analyses and study findings were derived after all data collection was completed, and participants were not invited to provide feedback on the findings.

BMI Measure

Because BMI is so frequently used in health care, clinicians were asked, "What are your thoughts on using BMI as a metric for measuring health and well-being?" A sample of their responses is included in the Table.

One of the most common themes that emerged in the qualitative analysis was that BMI was a useful but inadequate metric. Clinicians provided various reasons for inadequacy, including the following: BMI is not encompassing of well-being, BMI does not account for other health indicators, and BMI is a potential cause of patient harm (eg, stopping patients from seeing their doctors, triggering disordered eating habits or negative body image, or feeling stigmatized). Two of the 10 clinicians referenced BMI as a standard that has no alternative. Regarding BMI being a useful metric, many clinicians referenced it being a baseline tool for assessing health. Although clinicians cited BMI as a useful metric in some situations, they also mentioned that BMI is an inadequate measure of health and well-being.

Facilitators to Respectful, Weight-Inclusive Care

Clinicians were asked to identify qualities of care or describe what ideal care would look like (embodying the HAES principles of respectful, weight-inclusive care). The most poignant theme that emerged was providing non–weight-focused care. Subthemes mentioned within this overarching theme included a shift away from weight-focused care, an emphasis on respect for the patient and providing patient-centered care, and employing a multifactorial approach to care. Clinicians had varying ideas on how this could be incorporated in the current health care system.

Barriers to Respectful, Weight-Inclusive Care

Barriers to respectful, weight-inclusive care identified by clinicians in the interviews also provided a wealth of diverse answers. The most poignant barriers identified were the need for clinician education, bias, stigma, and employing weight-centered care (see Figure).

DISCUSSION

Conducting a small pilot study to gather initial insights from a small group of clinicians may lead to future research and greater adoptability of HAES principles in clinical care, resulting in better patient outcomes and reduced stigma. From the small sample of clinicians interviewed for this study, it is clear that while they viewed BMI as a helpful tool that is useful in some scenarios, it does not encompass a patient's well-being and has the potential to cause the patient distress (eg, perpetuating weight stigma). Participants shared a variety of ideas to improve weight-related health care, such as providing patient-centered care and shifting away from weight-focused care. They also identified shortcomings in the current system that serve as areas for improvement, including bias, stigma, and the need for clinician education.

While this pilot study provided insight into weight stigma and its role in health care from the clinician perspective, several limitations exist. The small sample size (n = 10) means that further research with larger, diverse samples are necessary. Clinicians interviewed were primarily from the Madison, Wisconsin area (n = 8) and worked within the same university health system; thus, views and perspectives may not reflect the opinions of clinicians who work in different settings and serve a different patient population. Additionally, knowing the interview was about weight stigma, clinicians may have been more inclined to discuss biases and shortcomings rather than successes regarding weight-inclusive care in the current health care system. Finally, selection bias is a limitation of this study, as clinicians who chose to participate had a prior opinion about or interest in the way weight is handled in medical care.

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Appendix: Available at wmjonline.org.

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