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Sunday, August 11, 2019

(Plenary)

11:25 - 11:50 Language, Respect, Engagement, and Assessment of the Obese Patient

Language, respect, engagement and assessment of New Zealanders living with obesity

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Disclosures: Professor John B Dixon



Bariatric Advantage

BUPA

I-Nova

Nestle Health Science

NACOS

NHMRC

Novo Nordisk

MISS

Obesity Australia

RACGP

Consultant

Research Support

Consultant

Consultant

Chair accreditation

Research Support

Advisory board and speaker fees

Co-director US surgical conference

Research Support

Everything You Know About Obesity Is Wrong

For decades, the medical community has ignored mountains of evidence to wage a cruel and futile war on fat people, poisoning public perception and ruining millions of lives.

HUFFINGTON POST
SEPTEMBER 19, 2018

How can we have got it so wrong?

Have we

Allowed stigma, bias and personal responsibility for obesity to completely control our approach to not providing care
Ignored the broad range of biological determinants generating obesity and its serious complication

Dismissed the biological imperative to regulate energy balance and the concept of abnormal regulation

Conveniently sidestepped the overwhelming pathophysiology indicating that obesity causes serious complications,
and bio- psycho-social-disability

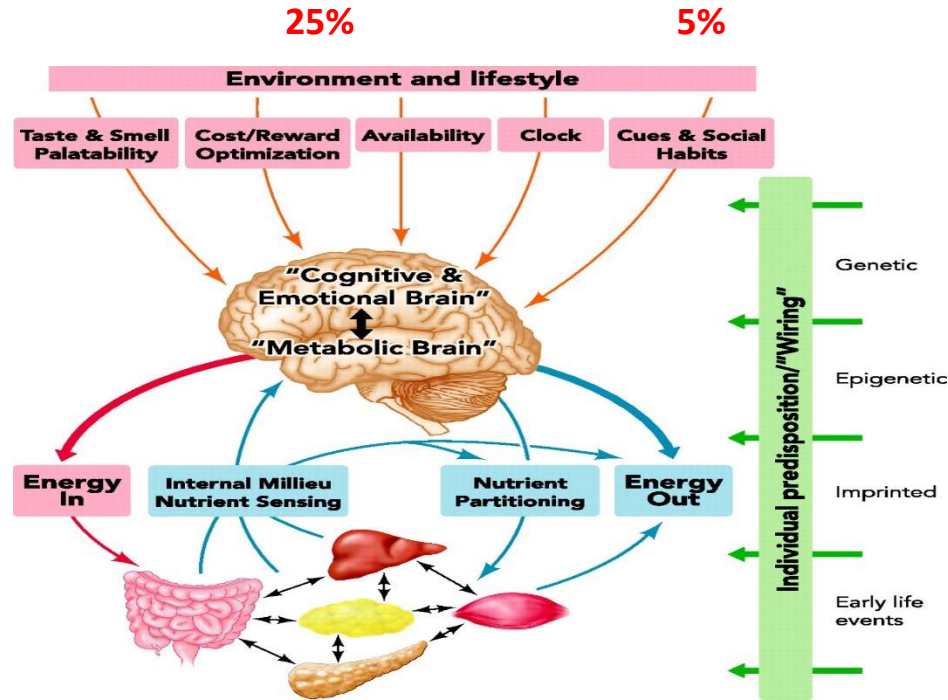
Blamed the individual for their current state of health and wellbeing. Thus down playing OUR role in prevention and
management

Convinced our patients and the rest of society that we are right.....and they have swallowed it hook line and sinker
“Because it’s obvious”... “because it makes perfect sense”! ... “We feel comfortable because WE can do nothing”

Yes, and the evidence overwhelming!

Can we fix it?

Schematic diagram showing the major factors determining neural control of appetite and regulation of energy balance



70%

Unfortunately a rise in weight (fat) is defended just as a rise in blood pressure is defended

Weight stigma:

- Social devaluation and denigration of people because of their body weight.
- Contributes to bullying, prejudice, unfair treatment, and/or discrimination.

Weight discrimination:

- Overt forms of weight-based prejudice and unfair treatment.
- Weight-based discrimination occurs in multiple life domains, including unfair treatment in the workplace, inequities in education, and prejudice in the health care setting.

Prevalence of perceived weight discrimination

9 Studies: Almost all U.S. national panels and nationally representative datasets (MIDUS, CARDIA); one Swedish study (ULF)

Pooled prevalence of perceived weight discrimination:

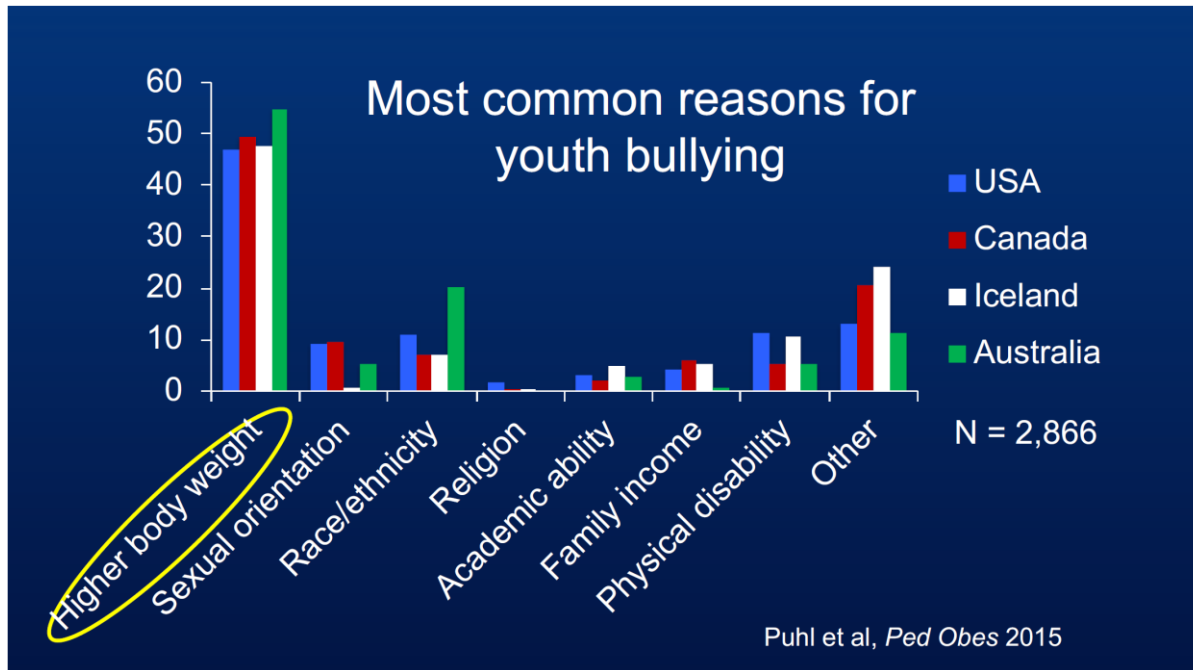
- 19.2% among individuals with class I obesity (BMI: 30-35)
- 41.8% among individuals with more severe obesity
- Higher prevalence in women than men
- Several studies found that younger adults and Caucasians were more vulnerable to weight discrimination

Youth enrolled in weight loss programs:

90% teased/bullied about weight from peers

37-60% teased/bullied about weight from parents/family

Puhl, Peterson, Luedicke, *Pediatrics*, 2012; Puhl & Himmelstein, *Ped Obes*, 2018



Getting our language right^{1,2}



Talking with our colleagues – person first language

- People have obesity, they are not an obese person – avoids defining a person by their disease
- Talking with our patients – be aware of not using judgmental or stigmatising language such as ‘fat’, ‘obese’, ‘overweight’ or ‘chubby’
 - Can cause offence and stigmatise
 - If people are upset, they are also less likely to hear and act on your important health message
- Using the term ‘above a healthy weight’ helps focus attention on the health and well-being of the individual, rather than their weight and may be a good option in some circumstances
- ‘Higher weight’ or referencing BMI (if individual familiar with this term) may also be appropriate
- “Ask permission to talk about weight” – **“How does your weight affect your day to day life”**

1. Meadows A and Daníelsdóttir S. *Front Psychol* 2016;7:1527.

2. Puhl R *et al. Int J Obes (Lond)* 2013;37:612–19.

Reframing our expectations

Your success is not determined by how much weight your patients can lose

- Obesity is a chronic, relapsing disease

A suggested approach:

- 1. Build rapport – don't try to solve the world in 20 minutes**
- 2. Ensure good communication – be authentic, humble and curious**

- Question your assumptions, you are not the expert in your patient's life

Reframing our expectations

3. Do not come from a point of power or authority – negotiate/facilitate goals

- Establish the interests of the individual about their health
- Identify barriers and solve problems together
- A focus on wellbeing, rather than disease, is often better (e.g. improved energy)
- Avoid focus on weight
- Ensure that goals can be measured and are time-limited

4. Be aware of gender differences

5. Normalise psychological distress and offer support



Reframing our expectations

6. Acknowledge that the treatment course may not produce the desired result

- Not meeting goals should be framed as a challenge rather than a failure
- Success can occur months or years after attempts begin – maintaining engagement is key

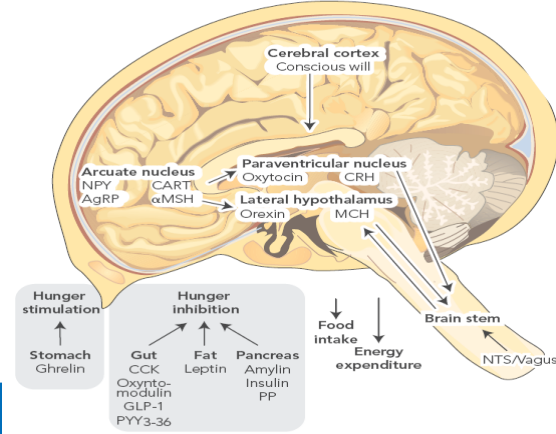
7. Celebrate small wins

- Success can take many forms and may not look like what you expect
- A change in health behaviours, or even body acceptance, could be considered a win

8. My approach: Show compassion let them know that you understand their issues and disease. *“It is NOT your fault and WE can help”*

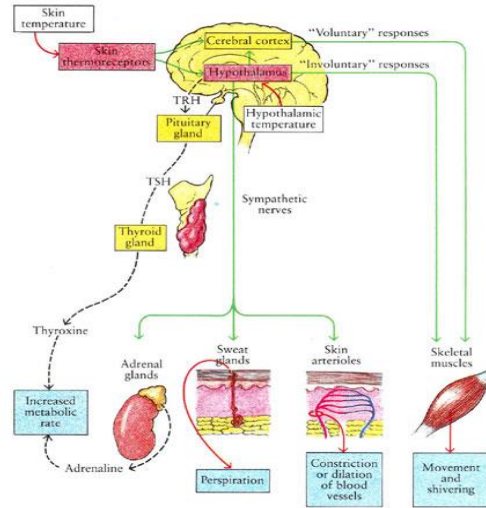
Obesity a disease of central dysregulation of energy balance

FAT

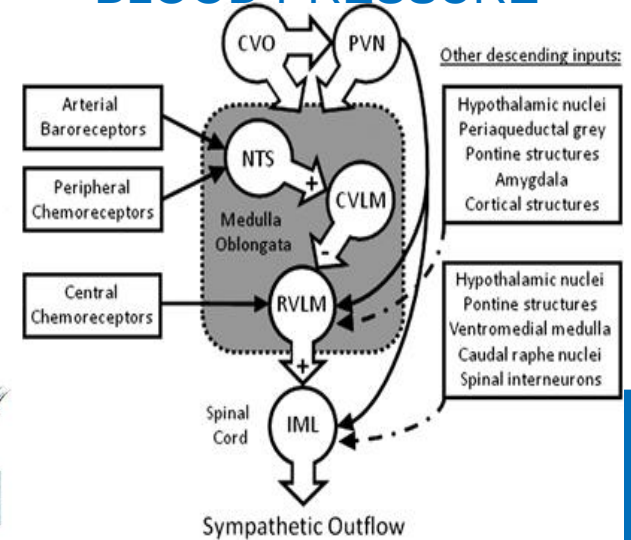


AgRP = agouti-related peptide. CART = cocaine and amphetamine-regulated transcript. CCK = cholecystokinin. CRH = corticotropin-releasing hormone. GLP-1 = glucagon-like peptide. MCH = melanin-concentrating hormone. αMSH = alpha melanocyte-stimulating hormone. NPY = neuropeptide Y. NTS = nucleus of the tractus solitarius. PP = pancreatic polypeptide. PYY = peptide YY.

TEMPERATURE

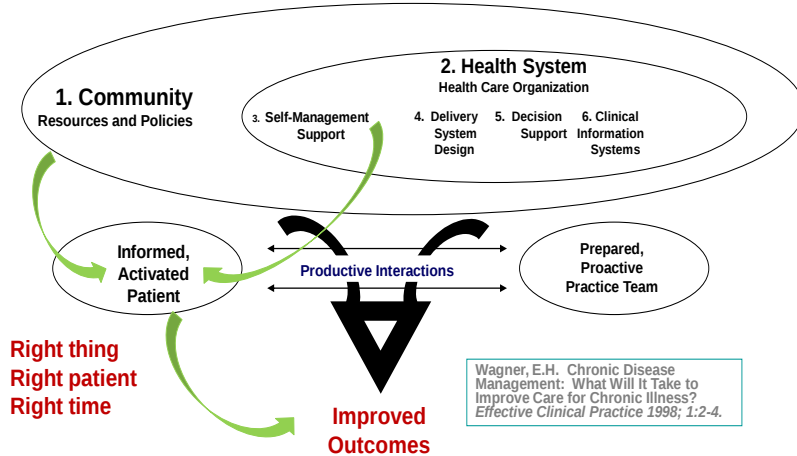


BLOOD PRESSURE

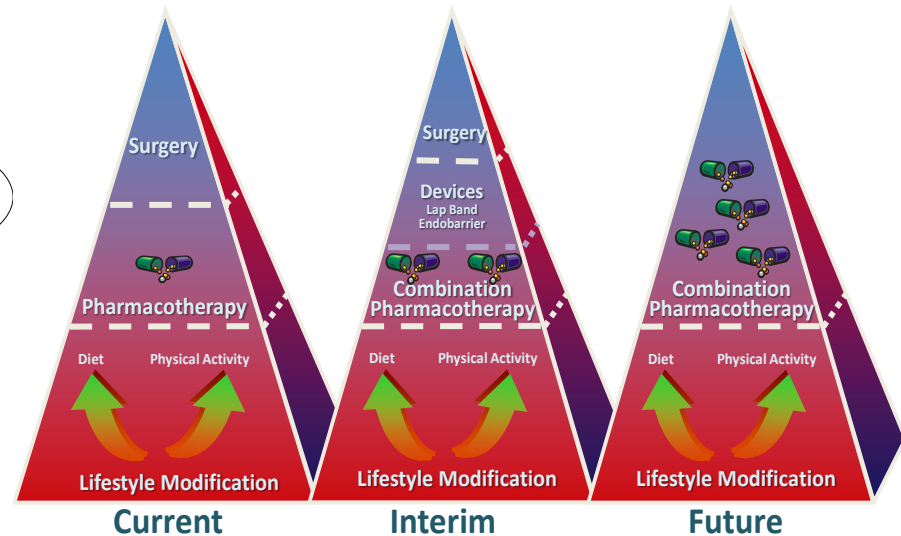


Obesity – Chronic relapsing disease

Chronic Care Management Model



Obesity Treatment Pyramid

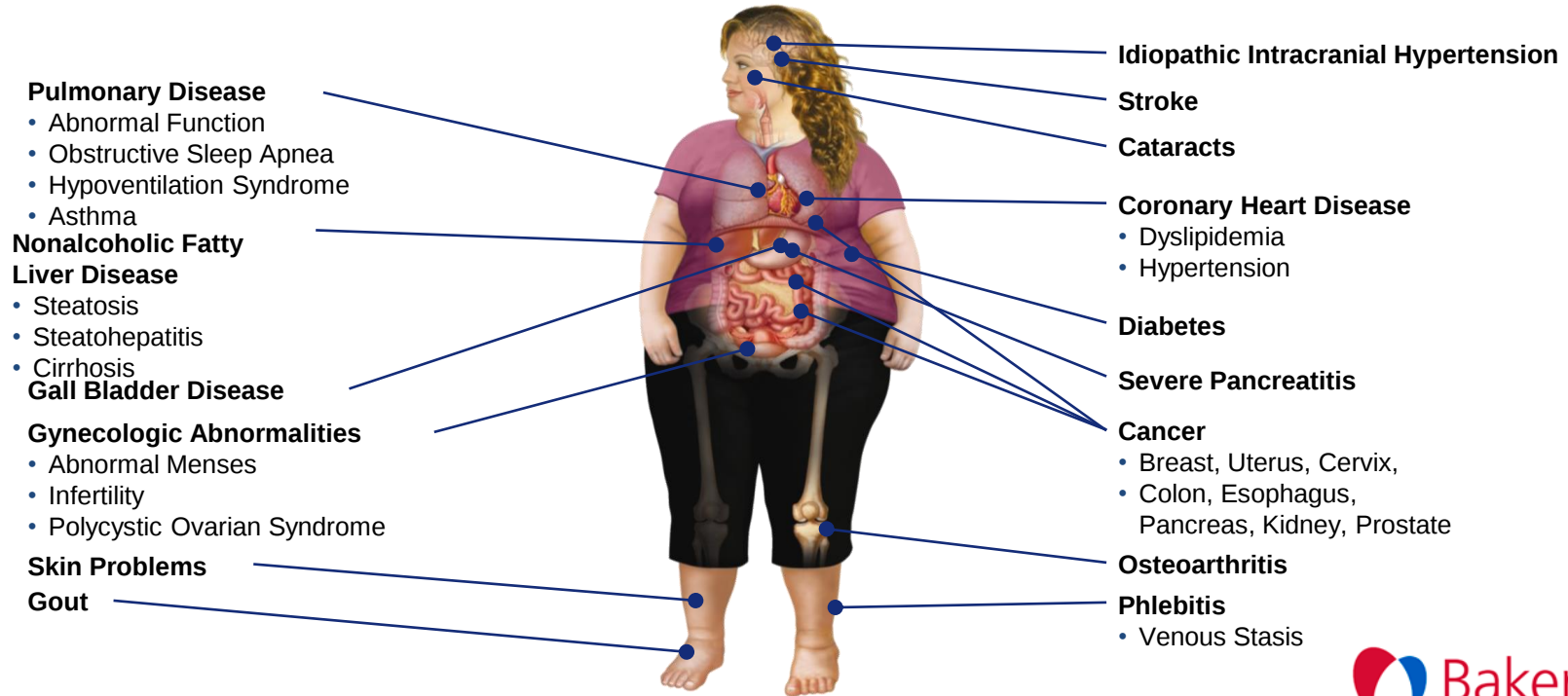


1.4 million Australians have type 2 diabetes
1.4 million Australians have clinically severe obesity

Obesity the canary in the mineshaft for chronic obesity related disease



Obesity-related Complications



Australian's with type 2 Diabetes 2011

Clinical Terms Used to Describe Various Levels of Body Fat*

NORMAL
BMI 18.5 — 24.9



12%

OVERWEIGHT
BMI 25 — 29.9



29%

Class I
BMI 30 — 34.9



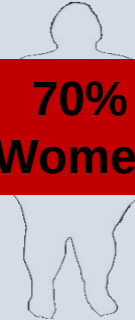
29%

Class II
BMI 35 — 39.9



16%

Class III
BMI ≥ 40



**70%
Women**

14%



Diabetes
MILES
Study

30% in the severely obese categories

* BMI (Body Mass Index): A measurement of an individual's weight in relation to height (kg/m²).

Dixon, J. B., et al. (2013). "Severely obese people with diabetes experience impaired emotional well-being associated with socioeconomic disadvantage: Results from diabetes MILES - Australia." *Diabetes Res Clin Pract* **101**(2): 131-140.

"Severe obesity and diabetes self-care attitudes, behaviours and burden: implications for weight management from a matched case-controlled study."
Results from Diabetes MILES-Australia

The Obesity Stigma

The same

HbA1c

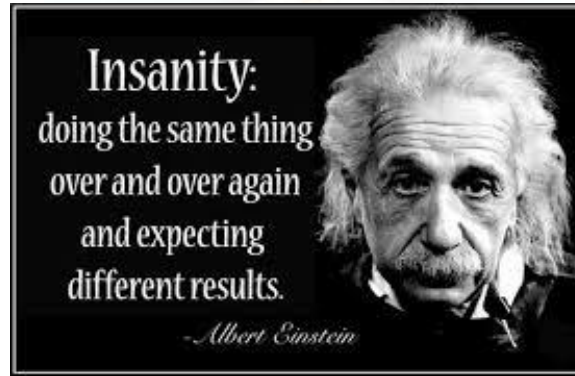
Medications

Eyes

Feet

Urine

Follow-up



Earn less money than slimmer co-workers

Lazy

<http://www.bellygonefat.com>

Different

Diet

Physical activity

Less important

Poor uptake

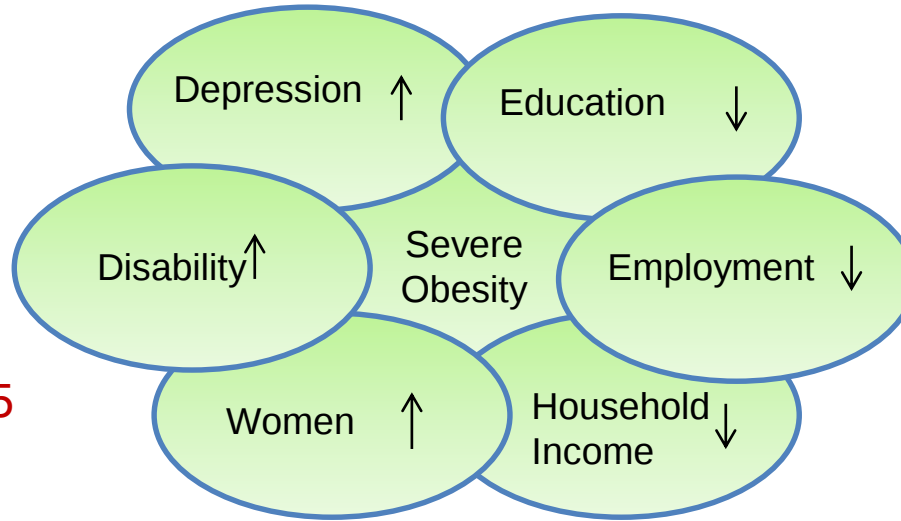
Greater barriers

The compounding stressors of severe obesity

2000 Australians
with type-2
diabetes
Mean BMI 32

A comparison of
those with BMI
>35 and those <35

Severely obese
BMI 35-40-45+



Along with obesity related disease this
presents complex management issues

More likely:

Unemployed
On disability pension
Living alone
To not spend on health
Not seek treatment for
depression
To not have private health
insurance

To use insulin
Younger and earlier onset
of diabetes

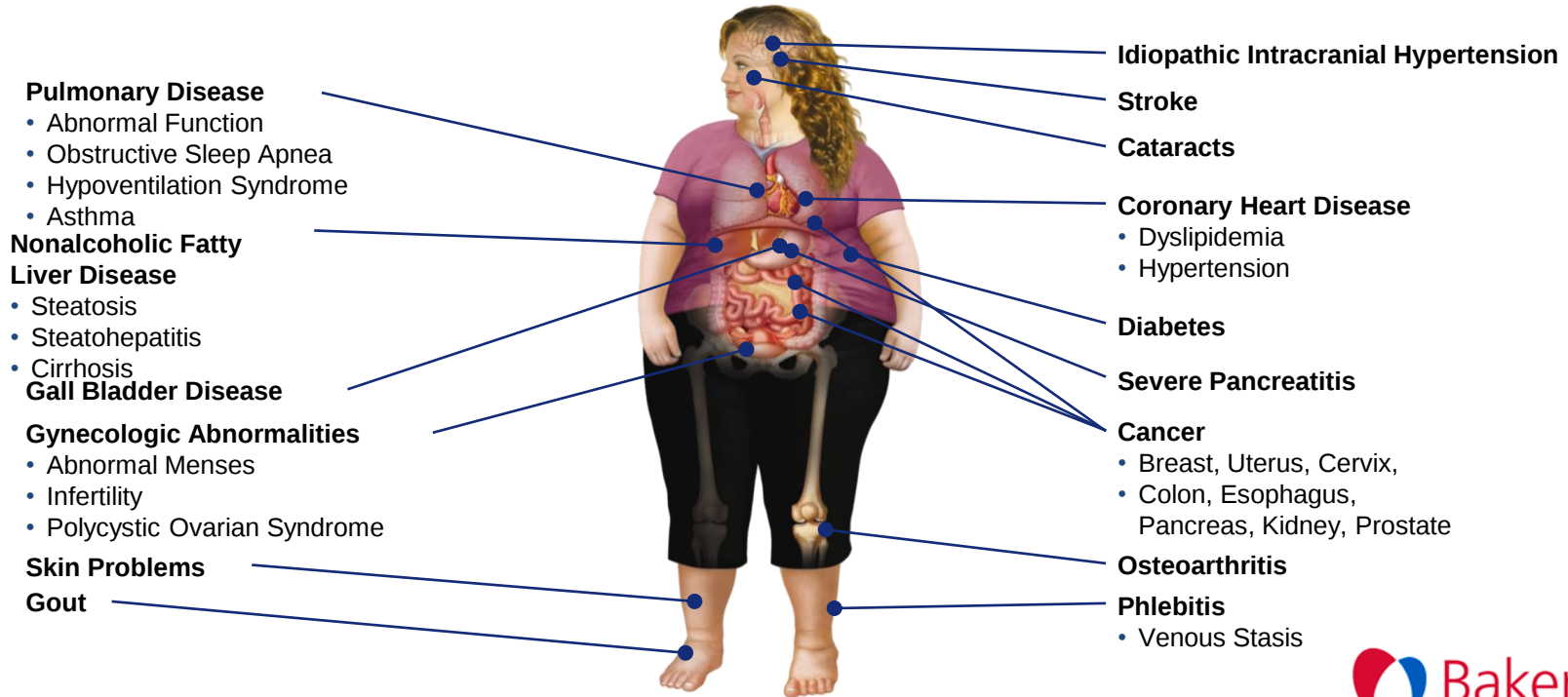
Dixon JB, Browne JL, Lambert GW, et al. Severely obese people with diabetes experience impaired emotional well-being associated with socioeconomic disadvantage: Results from diabetes MILES - Australia. *Diabetes Res Clin Pract.* 2013;101(2):131-140.



Obesity the canary in the mineshaft for chronic obesity related disease



Obesity-related Complications



Assessment:

Normalise the measurement of height and weight (BMI) in your practice

If the body mass index is <35 measure the waist circumference (Its always in the high risk zone if the BMI is >35).

Neck circumference is a good metric to predict OSA in men and women. And ovulation in premenopausal women.

Take Blood Pressure using an appropriate cuff – you need big cuffs

Metabolic-Nutritional essentials: Fasting glucose, HbA1c, lipid panel, LFT, TFT, hs-CRP, FBE, U&E, Urine Alb/Cr ratio, Iron studies. (others as clinically appropriate)

Consider: Sleep study (home), Respiratory-sleep referral, others

Nutrition – dietitian if at all possible

Assess Physical function

Putting this in packets is useful conceptually

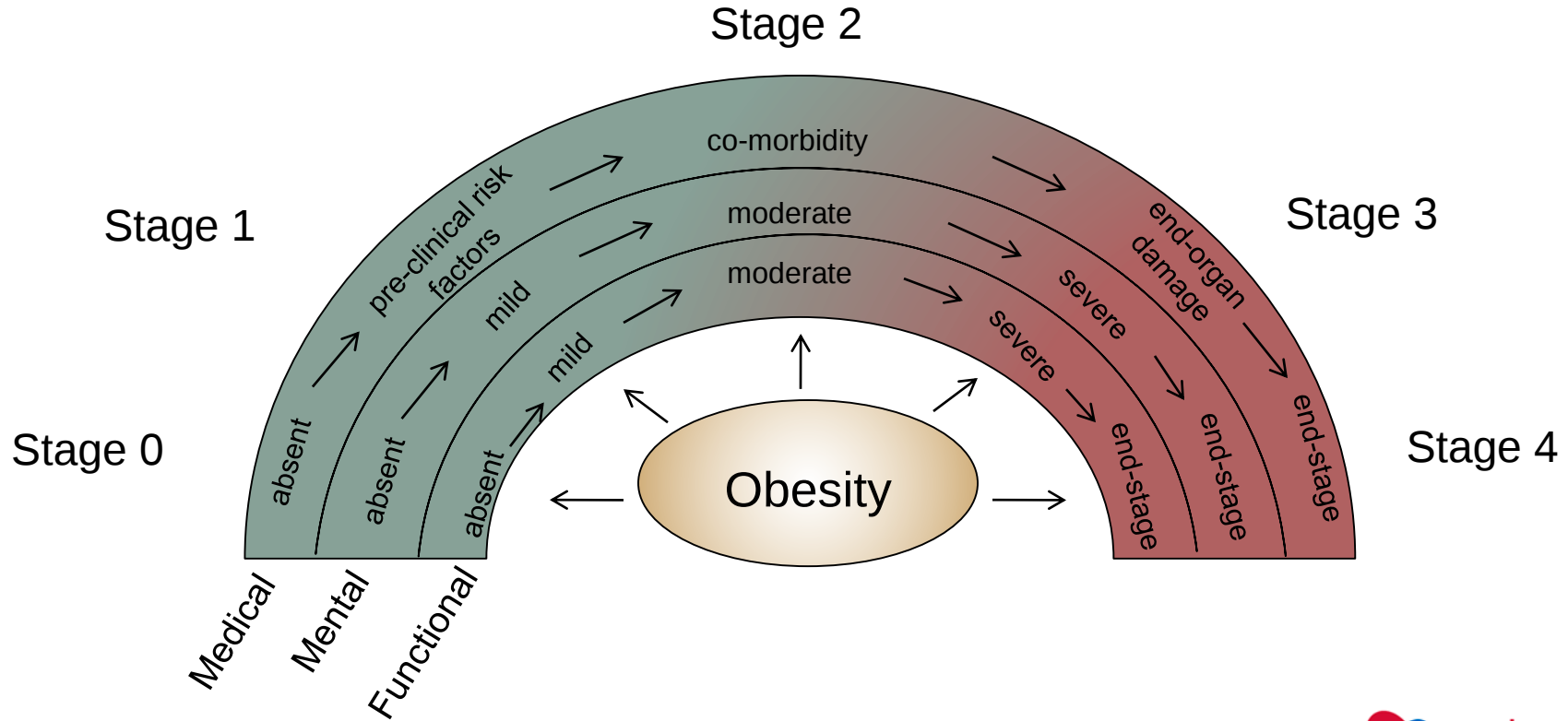
Cardio-metabolic-inflammatory

Mechanical

Functional

Psycho-social-demographic

Edmonton Obesity Staging System



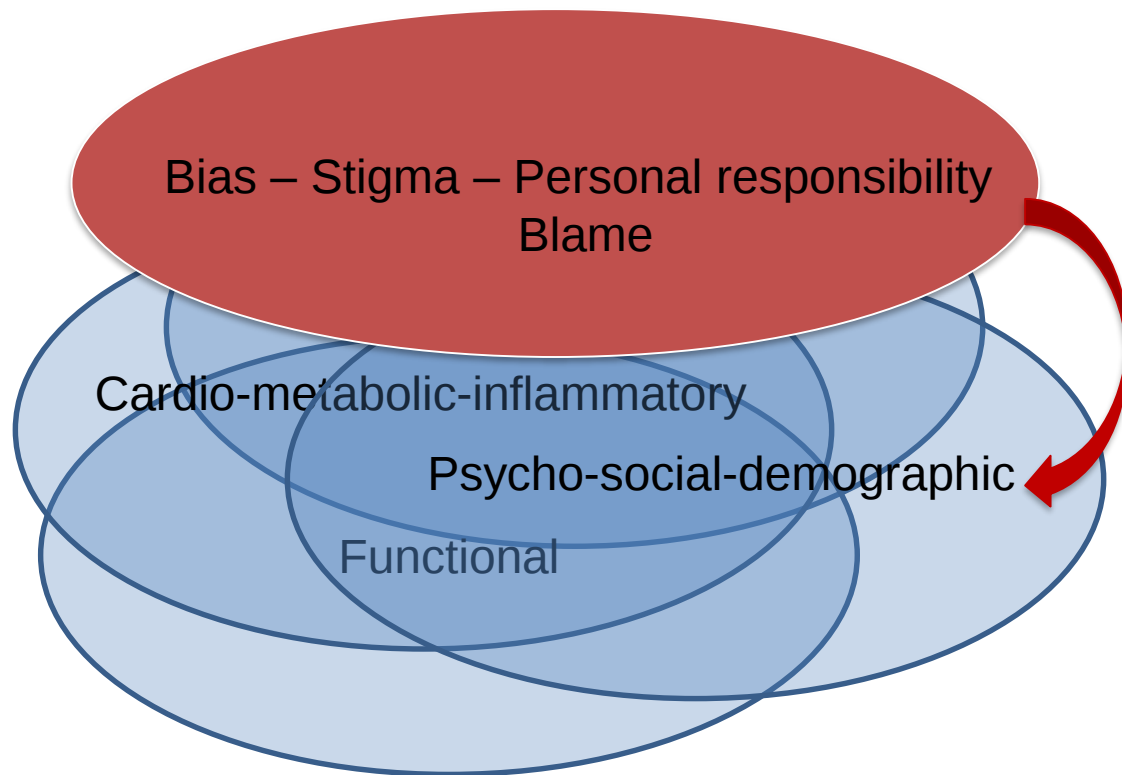
Sharma AM & Kushner RF, *Int J Obes* 2009



Edmonton scoring system

Stage	Description
0	No apparent obesity-related risk factors (e.g., blood pressure, serum lipids, fasting glucose, etc. within normal range), no physical symptoms, no psychopathology, no functional limitations and/or impairment of well being
1	Presence of obesity-related subclinical risk factors (e.g., borderline hypertension, impaired fasting glucose, elevated liver enzymes, etc.), mild physical symptoms (e.g., dyspnea on moderate exertion, occasional aches and pains, fatigue, etc.), mild psychopathology, mild functional limitations and/or mild impairment of well being
2	Presence of established obesity-related chronic disease (e.g., hypertension, type 2 diabetes, sleep apnea, osteoarthritis, reflux disease, polycystic ovary syndrome, anxiety disorder, etc.), moderate limitations in activities of daily living and/or well being
3	Established end-organ damage such as myocardial infarction, heart failure, diabetic complications, incapacitating osteoarthritis, significant psychopathology, significant functional limitations and/or impairment of well being

Reality tells us a very different story and the pathophysiology of obesity related complications are likely to have contributions from all!



Stigma: “the negative associations felt by and acted upon an individual based on one or more of their personal characteristics.”

Body weight is perceived as something we can control.

Lack of personal responsibility: lazy, no willpower, unsuccessful, unintelligent, recidivist and lacking self-discipline

A lack of personal responsibility and CONTROL

Shaming and blaming “will encourage them to lose weight”

The media has a ball “The biggest loser” & “Dr Phil”

And acted on by the individual

Perceived weight stigma-discrimination is significantly associated with increased risk for chronic stress, atherosclerosis, diabetes, dyslipidaemia and myocardial infarction

Weight gain and central obesity

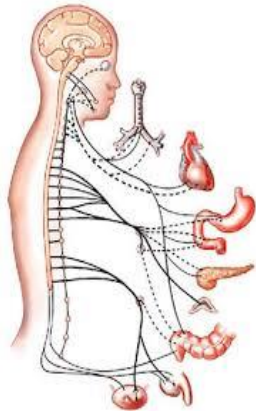
Poor self-esteem, self-image, depression, reduced social engagement and social isolation

Whitehall II study

Among women, work stress was associated with higher risk of T2DM in the obese (HR 2.01: 1.06; 3.92), but not in the non-obese

Gender and body weight status play a critical role in determining the direction of the association between psychosocial stress and T2DM

Obesity (Silver Spring). 2012 Feb;20(2):428-33. doi: 10.1038/oby.2011.95. Epub 2011 May.



Chronic Stress

HPA –axis

SNS activation

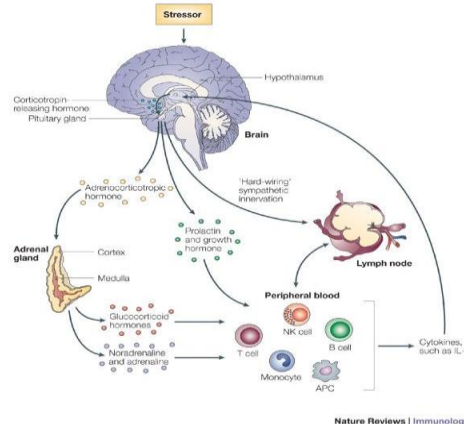
Gut brain axis

Immune modulation

Gut microbiome

Inflammation

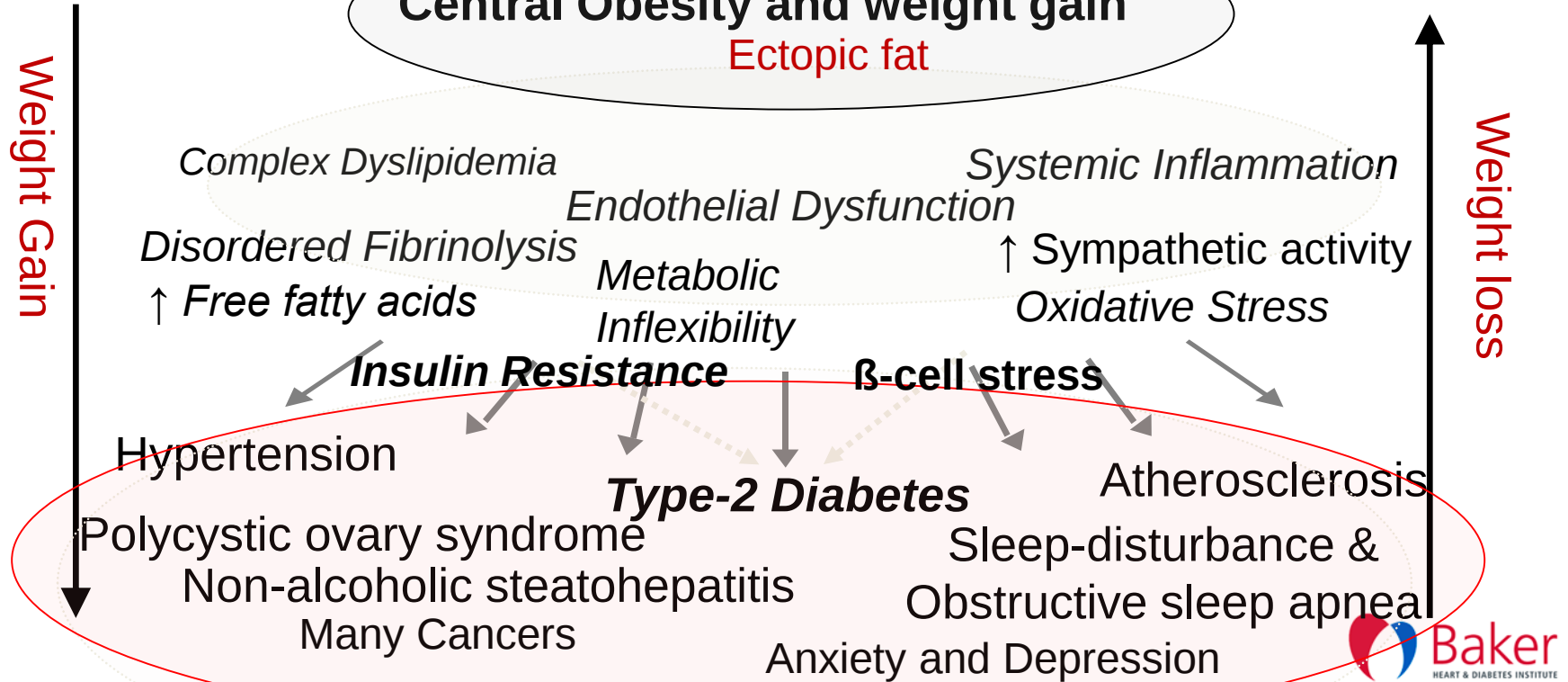
Obesity - metabolic



Obesity related type-2 diabetes

One result of Metabolic and inflammatory cascade driven by

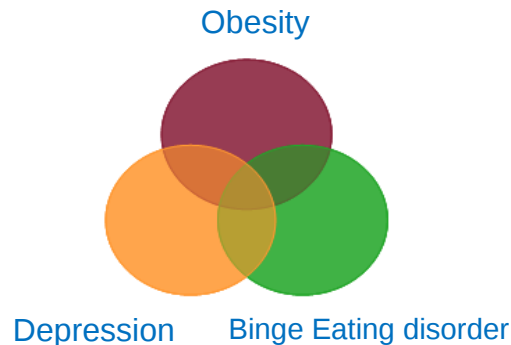
Stigma - Stress
Central Obesity and weight gain
Ectopic fat



Psycho-social demographic



Frustration in the lack of efficacy in lifestyle intervention



Major depression linked to impaired glucose tolerance

<http://www.medscape.com/viewarticle/703923>

Depression associated with:
obesity, inflammation,
sympathetic activation,
activation of the HPA axis

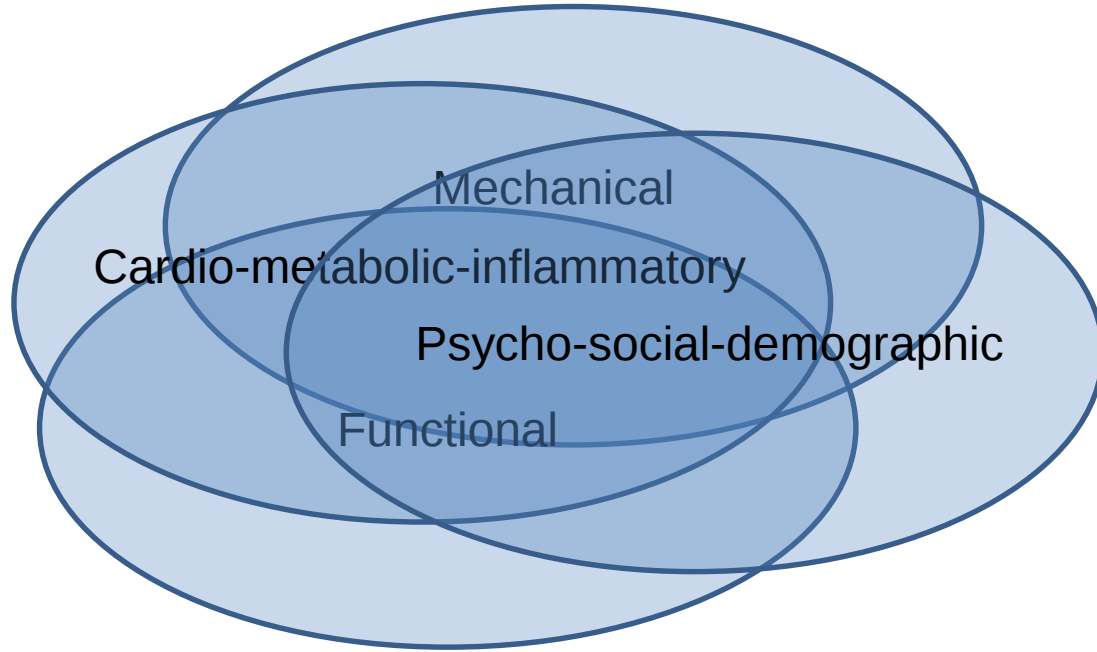
Young JJ, et al, *J Affect Disord.* Dec 2014;169:15-20.

SSRIs possess significant anti-inflammatory properties

A rethink in mode of action?

Walker FR; *Neuropharmacology.* Apr 2013;67:304-317.

While conceptually we can divide the complications of obesity into packets the individual with obesity has their pattern of dysfunction and disease



Respect

Dignity

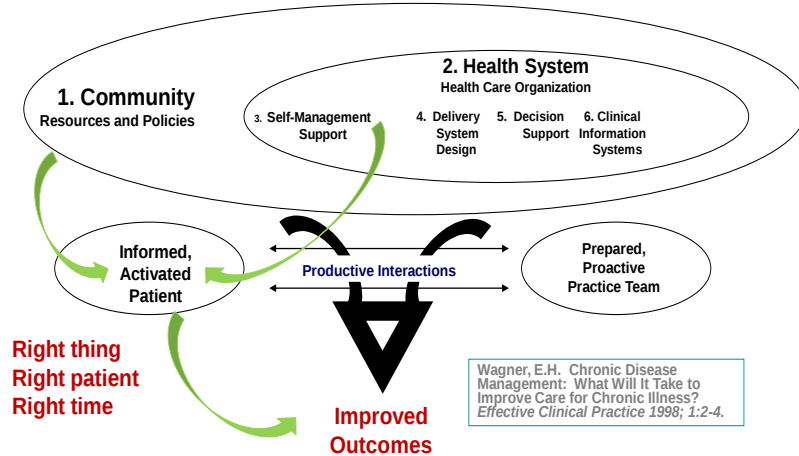
Compassion

Professionalism

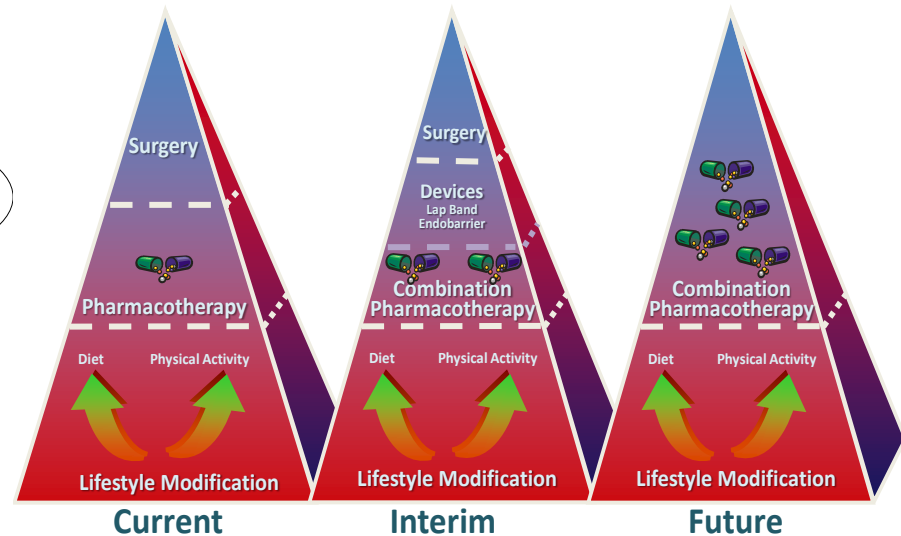
No Blame

Obesity – Chronic relapsing disease

Chronic Care Management Model



Obesity Treatment Pyramid

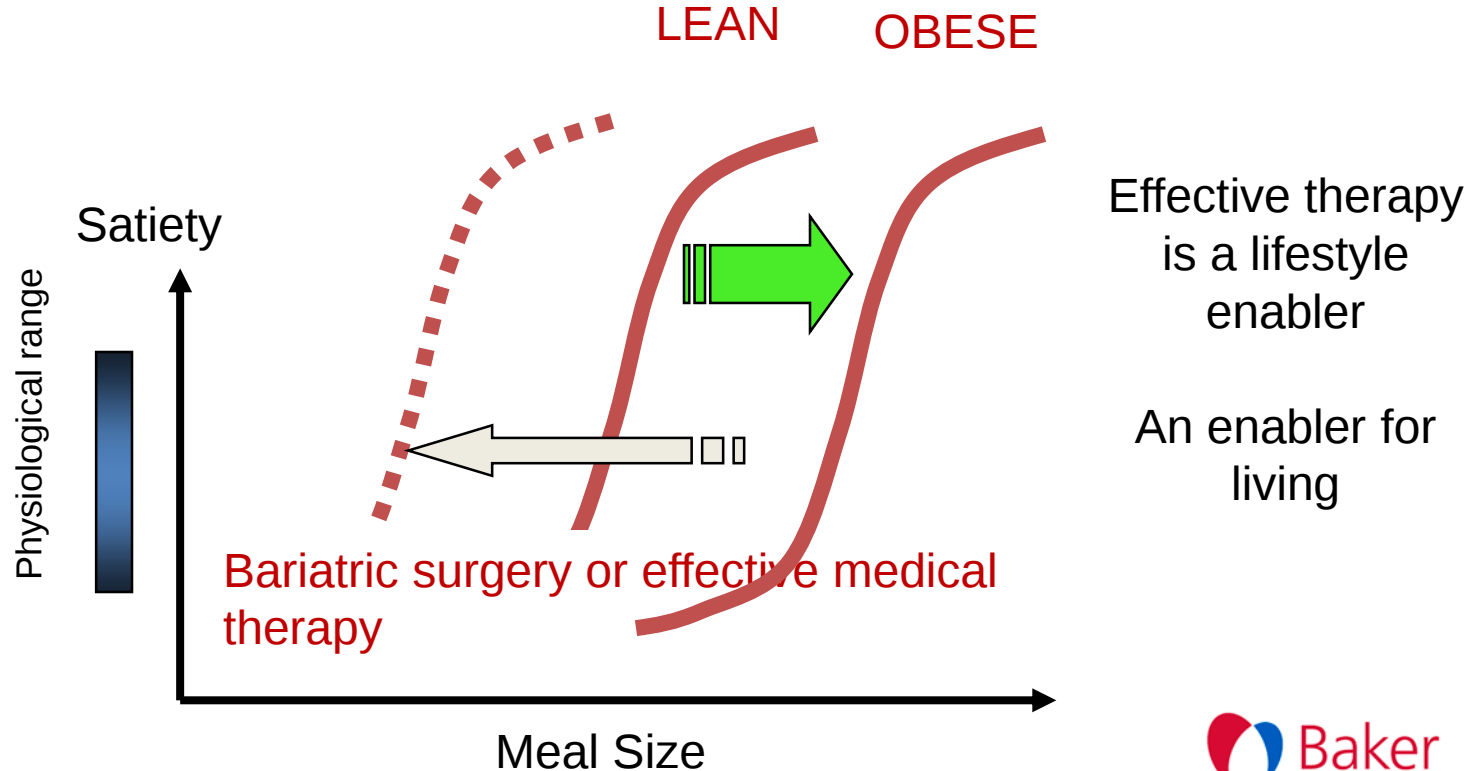


Transdisciplinary - patient centred care

Self-management support and engaging the patient in their own care is not the same as motivated to change behaviours

Dose response curve

“A change in regulation”



Bias – stigmatisation – also applies:

- Effective therapies:

- No effective drugs listed on the PBS
- Trivial access to bariatric metabolic surgery in public hospitals (1:22)
- VLCD – meal replacements, growing list of effective drugs, bariatric metabolic surgery
- Gross therapeutic inertia <5% with an indication for effective therapy receive care beyond lifestyle advice

Its my fault why
should I be a
health care priority

- Researchers in the area or obesity:

- Richard Atkinson: TOS Awards: George Bray warning to Dick on taking up a career in obesity research
 - If you go into obesity research you will be exposed to bias, and stigmatisation from all angles
 - It will be difficult to get funding
 - And your work will not be respected in the same way as other clinicians and scientists



Young adults have the greatest impairment in mental QOL

Adolescents with obesity seeking intentional weight loss have significant impairment in physical aspects of HRQOL, but self-reported mental HRQOL appears to be similar to adolescent community controls.

In contrast, obese participants in their 20s (17-27 years) report clinically significant impairment in mental HRQOL.

Mental aspects of HRQOL were at a NADIR in the 20s and significantly lower than adolescents and those in their 30s. By age 60 mental HRQOL in those seeking intentional weight loss was normal

We need a greater understanding of the emotional distress reported by those seeking intentional weight loss as young adults

Obesity – disease – complications

This is a serious chronic relapsing disease

There are many targets for intervention and improving health outcomes

They extend well beyond weight loss

Bias – Stigma – Shame and Blame are not elements of chronic disease management

Aims of Chronic Disease Management

Reduce mortality

Cardiovascular – diabetes - Cancer

Reduce morbidity

Reduce end-organ damage

Heart – liver – pancreas – joints - brain

Improve function

Physical – Mental – Cognitive – Sleep - Social

Improved psychosocial well being

Improved quality of life

Stigma around anxiety is far lower than you may think – The Age 15 Oct 2018

“Beyond Blue on line survey”

Two in three people with an anxiety condition believe others may see it as "a sign of personal weakness", but Beyond Blue found the perception of stigma did not match reality.

90% per cent of people believe anxiety is a real medical illness, 86% of those surveyed said they did not consider it a weakness.

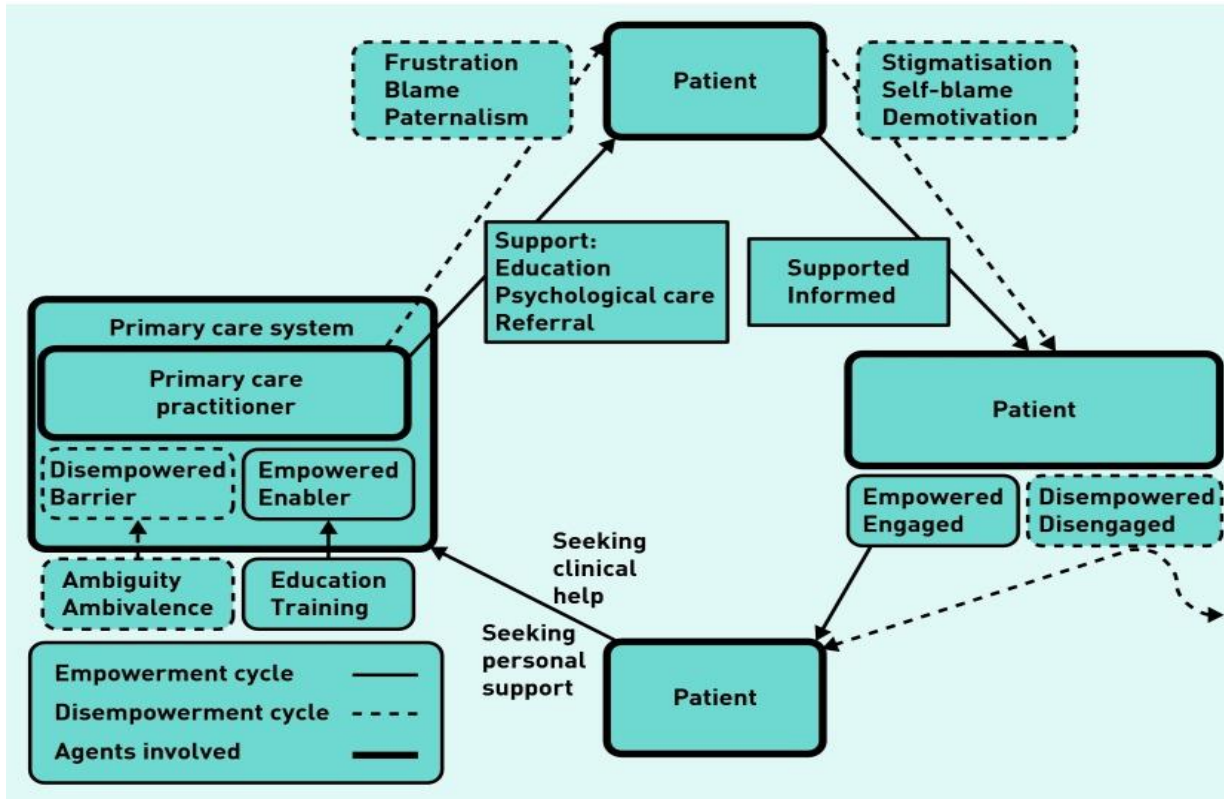
86% do not believe the condition is something "you can just snap out of".

"The self-shame, self-stigma and fear we place on ourselves is stopping people getting better" Beyond Blue CEO, Georgie Harman

She wants people experiencing an anxiety condition to know others do not judge them as "weak".

Obesity in primary care

Patient – Practitioner perspective on roles and responsibilities

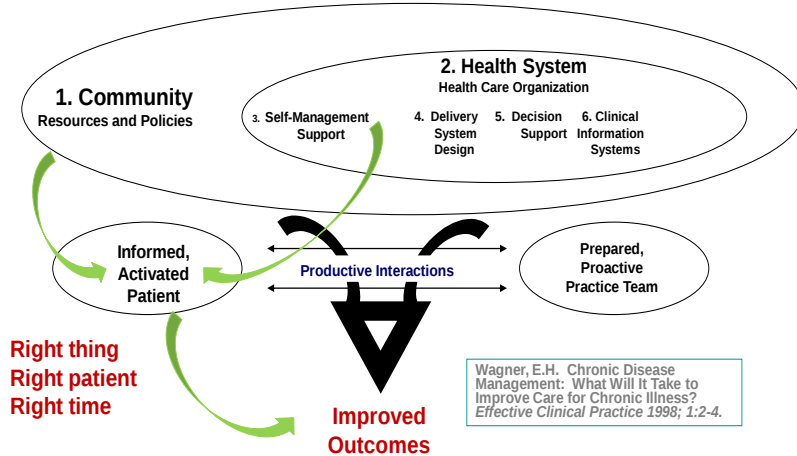


“Weight bias is ubiquitous in society as a whole.”

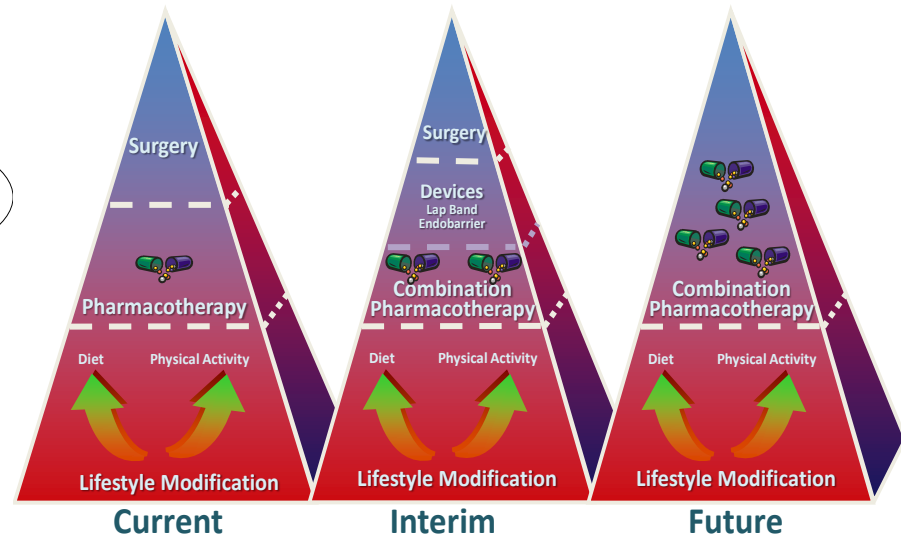
Doctors are part of society.”

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Obesity Treatment Pyramid



1.4 million Australians have type 2 diabetes
1.4 million Australians have clinically severe obesity

How can we have got it so wrong?

Can we fix it?

We need to accept our errors and actively correct misconceptions

Health care workers, researchers, and scientists need to promote evidence and dispel myths - Effective messaging and communication

Advocacy: Those impacted by obesity and related conditions need the support to address the damaging bias-stigma-shaming-blaming. Patient based advocacy organizations form the basis of community measures to change perceptions and demand better prevention, management and health outcomes.

National priority and planning

Until we can stop shaming and blaming we will not seriously address the prevention or management of obesity and its complications