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Weight Stigma in Post-MBS Care: Meta-Perspectives of Primary Care Providers

Afton Koball, PhD, ABPP

Associate Professor of Psychology

Mayo Clinic, Rochester, Minnesota, USA

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The Future of Obesity Management:
From Weight Loss to Health Gain

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Disclosure Slide

Nothing to Disclose

Background

Weight Stigma is the social devaluation, stereotyping, and discrimination directed at individuals because of their body weight.

- Negative Stereotypes
- Prejudiced Attitudes
- Discriminatory Behaviors

Clinical Relevance: Associated with maladaptive eating, lowered physical activity engagement, healthcare avoidance, increased stress and cortisol, depression, low self-esteem, higher rates of self-harm/suicide (youth), weight gain, obesity.

After MBS, weight stigma experiences may persist or return with weight recurrence.

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(Brown et al., 2022; Nutter et al., 2024; Puhl RM, 2020; Bennett et al., 2022)(Farnsworth et al., 2026)

Background

- Longitudinal followup of patients after MBS typically occurs in primary care
- **Primary Care Providers** (PCPs) play a critical role in reducing or perpetuating weight stigma

(Bennett et al., 2022; Farnsworth et al., 2026)

Study Objectives

- To explore perspectives of PCPs who provide healthcare to patients after MBS, understanding contributors to and mitigation strategies for weight stigma.

Methods

- International qualitative study
  - USA & Sweden
  - Semi-structured interviews
- **Eligibility:** Experience in providing healthcare to adults after MBS
- **Recruitment:** Purposive, snowball sampling Sept 2024-Mar 2025
- **Data Analysis:** Reflexive Thematic Analysis
  - Secondary Analysis

(Tolvanen et al., 2026)

Participants

Table 1. Study participants from the US and Sweden (n=38)

	US (n=16 (%))	Sweden (n=22 (%))
Profession		
General Practitioner	8 (50.0)	11 (50.0)
Resident Physician	0 (0.0)	4 (18.2)
Nurse Practitioner	8 (50.0)	0 (0.0)
Physician Assistant	0 (0.0)	0 (0.0)
District Nurse, Specialist Nurse, Registered Nurse	0 (0.0)	7 (31.8)
Gender		
Female	14 (87.5)	18 (81.8)
Male	2 (12.5)	4 (18.2)

Thematic Analysis Results

- **Three Primary Themes:**
  - Unconscious Biases in Primary Care
  - Structural Drivers of Weight Stigma
  - Countering Weight Stigma through Patient-Centered Care

Results: Theme 1

- **Unconscious Biases in Primary Care**
  - Assumptions about non-adherence
  - Weight recurrence framed as "personal failure"
  - Bias may be unintentional, but harmful

What is behind patient's experience of weight recurrence?

"It's that, you know, whenever I'm stressed, or whenever I'm depressed or I'm anxious I'll eat…" [Participant #2]

"I think I think there's the lack of nutrition education…" [Participant #6]

"I mean, I think that so much of weight management is so much in our heads, you know?" [Participant #7]

"But alternatively, you have the patients who have the weight loss surgery do the kind of the bare minimum, don't exercise, don't follow a good diet, then I can see that going down and then maintaining for a little while, and then kind of going back up, which I think has been the case with a couple of my patients that were at the point where we're on glp 1s now." [Participant #9]

Results: Theme 2

- **Structural Drivers of Weight Stigma**
  - Limited access to resources
  - Institutional and societal influences

"It would be nice to have some more resources for those patients of like how to connect and how to how to help them, get back on the horse and get back on things after the surgery weight gain." [Participant #3]

"…but many people need ongoing support to maintain…" [Participant #8]

"[Patients feel] Just profound disappointment and just really touches on that feeling of failure where they already had that [feeling] going into the surgery. Because this is really that last effort, right? This is the last hope, and, you know, no matter how you approach it, before the surgery, and even after, they still feel that way. And there's a lot riding on this and there's a lot that goes into it. It's really very upsetting to them [when they experience weight recurrence]." Participant #4

Results: Theme 3

- **Countering Weight Stigma through Patient-Centered Care**
  - PCP's noted strategies to combat weight stigma such as:
    - Supporting patient autonomy
    - Using nonjudgmental communication
    - Showing empathy
    - Recognizing complexity of weight maintenance

"Sometimes I'm a person they know well, so they might feel more comfortable with me than they do their surgery team. But I think there's also a level of shame of like, I went through all this, and I lost the weight, And now I put it back on, you know, again." [Participant #3]

"And I usually just say things like, Oh, you know, you're really brave to talk about things like this. And look at how far you've come. And this is a hard journey." [Participant #4]

"I have a few patients who have food insecurity, so it's cheaper to eat unhealthy foods than it is to go and buy fresh fruits and vegetables. Because, you know, if you're going to be hungry you're gonna buy what you can afford versus being hungry. So, you know, it's a complex social dynamic" [Participant # 8]

Conclusion

- Weight bias from PCPs exists after MBS
  - Often unconscious
  - Negative implications for patients
    - Impacts recommendations and referrals
    - Internalized weight stigma
  - Empathetic, sensitive PCP communication may buffer negative impacts of weight stigma

- Ongoing need for PCPs to be aware of complex, multifactorial causes of weight recurrence after MBS
- Call for greater collaboration between MBS teams and PCP
- Consider integrative strategies in primary care to address recurrent weight gain post-MBS

(Tolvanen et al., 2025)

TABLE 1 | Considerations for healthcare providers when engaging with patients with obesity [54–57].

Considerations	Detailed recommendations
Creating a size-inclusive environment	Ensure that waiting and consultation rooms are welcoming and have size-inclusive furniture and equipment, for instance: Stable scale that stands in privacy Sofas or armless chairs Sturdy examinations table Blood pressure cuffs, patient gowns available in various sizes
Addressing patient priorities	Address the issues that are most important for patient first. For instance, "is there anything specific you want to talk about today?"
Opening the conversation	Address the topic of weight with sensitivity, ask permission to discuss. For instance, "Would it be ok to talk about your weight today?" If patients do not want to discuss weight at that time, their decision should be respected.
Stigma-free communication	Validate and show empathy for weight stigma experiences Discuss the multi-etiological factors that contribute to weight and weight gain including biology, genetics, and environment (in addition to behaviors) Employ person-centered, non-stigmatizing communication style (e.g., Motivational Interviewing (MI)) Avoid assumptions about habits (e.g., assuming a patient of higher weight doesn't exercise)
Language choices	Utilize person-first language and non-stigmatizing terminology, and use patient-preferred terminology when possible For instance, "person with obesity", "having a higher weight," "your weight," "high BMI"
Weight-neutral approach	Shift focus of conversation from weight or weight loss to health markers and health behaviors
Consider patient perspectives	Seek to understand patients' perspectives on weight and health. For instance: What are your thoughts about the management of weight and health? In what ways is your weight impacting your everyday activities? What are your ideas for the next step?
Be collaborative, supportive, and respectful	Engage in shared decision-making, offer support and propose further treatment options. Support patient with expectations and realistic goals. Respect the patient's decision to decline additional interventions if they choose so. For instance: Could you describe your past attempts and strategies for weight reduction? Would you like to receive any support for weight management? May I provide you with further information regarding the treatment options? What are your thoughts on these options? Do you have any additional questions?
Following-up	Acknowledge the progress, validate challenges, and revise the treatment plan if needed

(Tolvanen et al., 2025)

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Q&A

Afton Koball, PhD, ABPP
koball.afton@mayo.edu

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