



The DEI Shift Obesity Mini-Series, Episode 1: Defining Obesity, Challenging Weight Bias

Transcript

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Learning Objectives:

1. Define obesity.
2. Summarize concerns about the origin and use of BMI, and the need for modified utilization in some patient groups.
3. Describe why people-first language surrounding obesity is important.
4. Explain how bias, whether explicit or implicit, leads to health disparities between patients with and without obesity.

[00:00-01:23] Introduction

Parker: Welcome to a special two-episode mini-series produced by members of The DEI Shift podcast team for the American College of Physicians with an educational grant from Novo Nordisk. In keeping with the mission of The DEI Shift podcast, which is to shift the way we think and talk about diversity, equity, and inclusion in the medical field, this mini-series will focus on how these elements impact the prevention and treatment of obesity in our patients of all backgrounds. I'm Dr. Brittäne Parker, an Internal Medicine Hospitalist and Co-Producer of the DEI Shift, joined by my co-host.

Walimbe: Hi, I'm Sanika Walimbe. I am a sophomore at the University of California, San Diego, studying cognitive and behavioral neuroscience, and I am a Production Assistant of The DEI Shift. This mini series is a part of the ACP's new curriculum on obesity management, which you can access anytime on the website www.acponline.org. We hope you enjoy these episodes and the larger curriculum as a whole.

Walimbe: In this first episode of the series, we want to address some key foundational issues about obesity, including how we define it and problematic aspects of our definition, and how weight bias and stigmas contribute to health disparities amongst patients with obesity. We have a wonderful guest who will be teaching us about these issues, Dr. Fatima Cody Stanford.

[01:23-03:23] Introduction to Guest

Parker: Yes, Dr. Fatima Cody Stanford is an obesity medicine physician-scientist, educator, and policymaker at Massachusetts General Hospital and Harvard Medical School. Dr. Stanford received her Bachelor's in Science and Master's in Public Health from Emory University as an MLK Scholar, her medical degree from the Medical College

policy maker at Massachusetts General Hospital and Harvard Medical School. Dr. Stanford received her Bachelor's in Science and Master's in Public Health from Emory University as an MLK Scholar, her medical degree from the Medical College of Georgia School of Medicine as a Stoney Scholar, and her Masters in Public Administration from the Harvard Kennedy School of Government as a Zuckerman Fellow in the Harvard Center for Public Leadership. After completing her Internal Medicine and Pediatrics residency at the University of South Carolina, she completed her Obesity Medicine and Nutrition Fellowship at Mass General and Harvard Medical School. Since completing her training, she has become a nationally and internationally sought-after expert in obesity medicine who bridges the intersections of medicine, public health, public policy, and disparities. She has served as a health communications fellow at the Centers for Disease Control and Prevention and as a behavioral science intern at the American Cancer Society.

Dr. Stanford has been honored with many awards from the American Medical Association and the American College of Physicians for her leadership. Just last year, she was honored as The Obesity Society Clinician of the Year. In 2021, she will be awarded the AMA Dr. Edmond and Rima Cabbabe Dedication to the Profession Award, which recognizes a physician who demonstrates active and productive improvement to the profession of medicine through community service, advocacy, leadership, teaching, or philanthropy. She was the chair of the committee that created the online modules for the larger ACP 2021 Obesity Management curriculum, which we will make sure to put a link to on our Show Notes.

In addition to all of this, she has been a guest on the Massachusetts General Hospital's Charged podcast, sharing her experiences practicing medicine as a Black woman, and listeners, you should definitely check out that episode after you're finished listening to this one. Dr. Stanford, welcome, and thank you for being here.

Stanford: Well, thanks so much for having me. It's an absolute delight to be here.

[03:23-05:23] Defining Obesity

Parker: So, let's get started on talking about how obesity is defined. Dr. Stanford, can you give us a definition?

Stanford: Absolutely. So, the most widely used definition of obesity here in the United States is based upon something we call body mass index or BMI, and what it does is it uses height and weight to determine one's weight status. So, this is taken from the World Health Organization, the Centers for Disease Control and Prevention, and it defines someone as having a normal weight status if their BMI falls between 18.5 and 24.9. A person is considered to have overweight when their BMI is between 25 to 29.9, and then when someone crosses that threshold of 30 is when we start to define them as having the disease of obesity. And we have mild, moderate, and severe forms of obesity, BMIs of 30 to 34.9 being mild obesity, BMIs of 35 to 39.9 being moderate or Class 2 obesity, and then severe and Class 3 obesity, a BMI greater than or equal to 40. The problem with the BMI being the end-all, be-all for determining one's weight status is it just tells me height and weight. It doesn't tell me the characteristic of that weight.

Let's say we have a patient that has heart failure, and we send them to the hospital to see Dr. Parker, for example, for diuresis of that extra fluid, and let's say they lose 20 pounds of fluid. Their BMI obviously has a major shift in a very short period of time. Did their weight status or their adipose, which we consider to be fat tissue, really change in the few days that it took to diurese off that much fluid because of their heart failure, or is the definition really not getting to, or is not a great proxy, I guess - BMI - of adipose or fat tissue? So, this is one of the major debates that we hear within the medical community that I think is quite sound, but the definition that I gave you is the one that we do utilize in medicine to determine whether someone has overweight or obesity.

[05:23-09:15] History and Flaws of the BMI

Walimbe: I'm so glad that you mentioned that, Dr. Stanford, because we've been learning a few things about the history of the BMI scale that we didn't know. So, the body mass index used to be called the Quetelet Index, after its founder Adolphe Quetelet,

Walimbe: I'm so glad that you mentioned that, Dr. Stanford, because we've been learning a few things about the history of the BMI scale that we didn't know. So, the body mass index used to be called the Quetelet Index, after its founder Adolphe Quetelet, who was a 19th century Belgian astronomer, statistician, and sociologist. He created and intended the index to be used as a population level measure based on the mean measurements of only Caucasian, specifically French and Scottish, men. His work trying to describe the "average man" ideal has actually been felt to have informed the fields of anthropometry, phrenology, and eugenics. Decades after the development of this index, it began to be correlated with life expectancy predictions, and actuary tables were being used by life insurance companies in the 1920s based off this flawed "index." So, the BMI has a complicated past that we must consider. And Dr. Stanford, you actually co-authored a Letter to the Editor article in the Mayo Clinic Proceedings Journal in 2019, advocating for the adjustment of BMI thresholds by sex and race/ethnicity, based on association with metabolic disease. Can you tell us more about that?

Stanford: Absolutely. So, I think that we just learned - I mean, I think you did a great history lesson on why BMI tables don't work, especially for people that look like me as a Black female physician, for example. Those Metropolitan Life Insurance tables, even if we're taking what happened in the 1920s and 1930s, did not include a diverse cohort of individuals by which we now decide and discern one's weight status. So, in this particular article for the Mayo Clinic Proceedings, I really wanted to see, is everyone the same? Should we really be capturing everyone the same, and if so, how close are we to what the Metropolitan Life Insurance tables told us?

In that particular study, we looked at NHANES, which is the National Health and Nutrition Examination Survey, data from just a few years prior to that where it was a diverse cohort of both men and women. So, we looked at Black, Hispanic, and White individuals, men and women. And we looked at major obesity-associated diseases, like hypertension or dyslipidemia, to discern where would you fall on the chart based upon these risk factors. What I thought was extremely interesting, particularly as a Black woman, which is exactly why I chose to pursue this field, is that the weight curve actually shifts up almost completely across the board for Black women, where we see a cutoff of 31 to 33 for most of the measures in terms of what's most at risk. Now, for men, almost across the board, the BMI, whether you're a Black, White, or Hispanic man, shifted downwards. So, are we really using the right tool to discern one's weight status? I would say that no, if we use the traditional standards.

In 2007, for Asian Americans, the charts were redone, and actually we did shift the BMI chart downwards to reflect Asians carrying more of what we call "central adiposity." That's that weight that's confined in the midsection which predisposes to metabolic diseases like diabetes, like fatty liver disease, for example. So, if we were able to do that back in, I think it was, 2007, then why have we not begun to look at that amongst really some of the major racial/ethnic groups here in the United States, especially if we see this disproportionate share of the burden of obesity in communities of color?

So, I hope that kind of gets into some of why I think that we need to make the shift, why I began to look at this work, and why this is, I think, still an extremely important piece of work that continues to need to be done so that we're using the best possible measures to ensure the best possible care for our patients.

[09:15-16:41] Weight-Based Biases and Stigma

Parker: Yeah, Dr. Stanford, I think that's so important, and in addition to evaluating the metrics we use to define and measure obesity, we also have to evaluate our own biases and how they can affect how we view and treat patients with obesity. Just like other members of our larger society, healthcare providers can often hold weight-based biases and stigma that impact how we care for patients, and therefore, how likely patients with obesity are to seek our help for the treatment of their disease and for other health complications and conditions. Our biases as providers can be explicit and overt, or they can come in a form that's more implicit, in which they're really unconscious and some can be even completely contrary to our beliefs. So, there's numerous studies that we have found, and we'll definitely place some of these in the Show Notes, of where physicians and nurse practitioners have shown that provider bias against patients with obesity can negatively influence our

...studies that we have found, and we'll definitely place some of these in the Show Notes, of where physicians and nurse practitioners have shown that provider bias against patients with obesity can negatively influence our assumptions about patients' adherence, their willpower, even their personalities. These biases can even affect the amount of time that clinicians spend with patients who have obesity compared to those who do not. And there was a really interesting article, it was in The Journal of Nurse Practitioners in 2016 entitled "Obesity Stigma and Bias." It really talked about the perceptions of weight bias and patients' perceptions of their care. And for patients with obesity who can also be people of color or part of other minority communities, their experiences of biases can be exponentially compounded upon. So, is that something that you also see in your work?

Stanford: Absolutely. I do whole lectures on this, so we'll see how much I want to share with you today, but I think this is extremely important. And I really want to start first with looking at just the language we use when we're talking about patients that have this disease of obesity. Throughout the podcast, you've heard our lovely hosts and myself talking about patients "with obesity". Instead of calling a patient "obese," I want you, as you're listening to this, to just delete the word "obese" from your vocabulary. "Obese" is a label and "obesity" is a disease. So, much like we use proper language, and we've evolved in this language when we're talking about patients that may have mental health disorders or maybe patients that have diabetes or whatever it might be, we need to make sure that we're giving patients with obesity the same dignity and respect that we do for those other patient populations. Now, it's also important for us to recognize that obesity is by far the most prevalent chronic disease that we are dealing with. I mean, 42% of US adults have this disease of obesity, and if we're treating that population, we're treating a very sizable percentage of the population in a very negative way.

So, let's look at the language. "Obese" you've already deleted; hopefully, you guys have deleted that. Let's look at the term "morbid," for example. We use "morbid" to *only* explain obesity, okay, but we don't use it to explain things that are killing people, such as COVID-19, at a very rapid rate. Why don't we call it "morbid COVID-19?" We really should, I mean, over 430,000 individuals are now dead in the United States alone, or we could call it "morbid cancer." I know of tens of thousands of people personally that have died from that, but why don't we do that? Because we don't devalue people that have COVID or people that have cancer in the same way we do patients that have obesity, because we think it's *their* fault.

So, a patient has a disease of obesity, and if we want to talk about the severity of the disease, let's just call it what it is: a patient has severe obesity. So, language matters in terms of our respect for this patient population. When we talk about our biases, our interactions with patients in the healthcare setting, nonverbal and verbal, can set up their entire interaction with the system. Let's say they come into your office, and they're of a body habitus that they don't have a chair to sit in, so they choose to stand up, not really because they want to stand, but because there's nowhere for them to sit down. That's sending a message to that patient that "you don't matter; there's not even a place for you to sit down." Let's say they go to get weighed on the scale, and let's say their weight is in this high or severe category, and then the medical assistant snickers, because the weight is so high. That's nonverbal communication before they've even made it back to me as the doctor to see them. And let's say they try to speak to the front desk staff and then are met with some resistance, here is now strike number three before they've even made it into the physician's office. So, when they get into the physician's office, they've already decided: "This is a place that's not welcoming." "There's no chair for me to sit in. People laugh at me when I get on the scale. People are not receptive to me at the front desk." So, you could see how everyone needs to play a role.

Now, they finally get to my office, and let's say I am a doctor that exhibits bias, whether it be explicit or implicit, and I say - they tell me - I'm like, "Oh, let me go over what you're eating," and they tell me, "Oh, I've been eating - in the morning, I have a protein shake with kale and berries," and then they give me a very, very healthy diet. And I look at them, and I say, "Are you really eating that?" I've immediately made the assumption that because they have severe obesity that there's no way their severe obesity can correlate with a very healthy diet. And indeed, I have patients that range from very low weight until like over 500 or 600 pounds, and so I have a really broad range of information to draw from that where I see patients that actually have severe obesity doing more than someone that's lean. So, someone that's lean can eat their jelly beans and their fried chicken or whatever.

have a really broad range of information to draw from that where I see patients that actually have severe obesity doing more than someone that's lean. So, someone that's lean can eat their jelly beans and their fried chicken or whatever, they don't really have to worry about it. Their arteries might have to worry about it, but they don't externally display that phenotype that is that person with a body habitus that says, "Look, I have this disease. Look, this disease is obesity. Look, this is my fault."

So, this bias piece is extremely important, and we know it actually impacts health outcomes. So, numerous studies, many of which have come out in *Obesity* the journal, have really demonstrated that actually there is a physiologic response to the stigma that one experiences where we see increases in hemoglobin A1C, increases in triglycerides, increase in CRP or what we call C-reactive protein, which we know is an inflammatory marker. These are all associated with this internalization of the stigma and bias that they often receive in the healthcare setting, the same place which is supposed to be warm, inviting, and welcoming to help them treat their disease.

So, it's like I said, I could keep going on and on, but I think these things are key, and I also want to think about that language piece, reminding you "obese" is deleted, "morbid" is deleted. A patient has obesity. A patient has severe obesity. We changed that language here in Massachusetts at the Massachusetts Medical Society in 2016, and we were successful in changing that language at the American Medical Association level in 2017. So, let's abide by it. Let's give our patients the respect they deserve. Let me tell you, they will appreciate it.

Parker: Yeah, thank you, Dr. Stanford. That is fantastic. I have to say, the members of The DEI Shift podcast and myself, we really enjoy these conversations with our guests, because we're continually learning. And when we first reached out to you to come on the podcast, you really told us to be cognizant of our language and sent us resources like that AMA policy on Person-First Language for Obesity in 2017. And I think what you said about how to mitigate bias, especially when patients are coming into the clinic and the signals that we can be sending, is really important to keep in mind.

[16:41-21:29] Tailoring Clinical Spaces to Patients with Obesity

Walimbe: So, as you were saying, Dr. Stanford, even in how these patients aren't even given chairs to sit in, our biases can come down to how our clinics are physically set up for our patients and how we measure and communicate a patient's weight when we're talking about vital signs at the start of their visit, and what terminology we use when we talk to our patients. Our listeners can read more about this in Module One of the larger ACP Obesity Management curriculum. But Dr. Stanford, we'd also love to hear from you how you set up your clinical spaces to mitigate weight bias.

Stanford: Absolutely. I'm glad you asked me that. So, in our center, we make sure that we have certain things that we pay very, very close attention to. Let's look at the door, first of all, that you have to open. There are some patients that are not able-bodied, meaning they do require assistive devices, so we make sure that you can get in our door and that our door is of a certain width that's much larger than a typical door opening, so they could get in with whatever assistive device if they do require that. When they do come into the waiting room, we've made sure that none of our chairs actually have arms. So, the reason why they don't have arms, or if they do have arms, they are wider like a bench, is because we don't want patients to feel like they can't sit down in the MGH Weight Center; that would be problematic. In addition, our scale goes up to, obviously, a very, very high level to accommodate patients that do require being on their assistive device, weighing both them and the patient simultaneously, and being able to subtract, or for those that just happen to have very severe obesity; so we're very mindful about that.

In terms of blood pressure cuffs, you can actually get a false reading if you're not using the right-sized blood pressure cuff. So, I have in my office four different-sized blood pressure cuffs in my individual room that I immediately will eye the patient without - in my brain I'm doing it - and I will make sure I use the right cuff. Because if I use the wrong cuff and they realize, "Oh, my arm was too large for that," you can imagine that that makes them feel quite embarrassed that "Oh, my gosh. The doctor couldn't use the right cuff." Similarly, I do waist circumference

Because if I use the wrong cuff and they realize, “Oh, my arm was too large for that,” you can imagine that that makes them feel quite embarrassed that “Oh, my gosh. The doctor couldn’t use the right cuff.” Similarly, I do waist circumference measurements on all of my patients. I measure at the umbilicus with just a tape measure around their circumference, and I also will eye it out and make sure I’m using the right-sized tape measure. Some tape measures aren’t quite large enough to capture some of my patients, and if they aren’t and if I don’t have the appropriate tool, then that’s not something that I should do, because then again, this tells them, “Oh, gosh. This is a typical tape measure. You can’t even fit inside that.” I didn’t say it, but they see it, and so I give them a lot of nonverbal cues if and when I don’t have the appropriate size. So, I’m very mindful about these things.

I think the key thing also is that when the patient comes in, and especially when they’re coming into a weight center, for example, they know why I’m seeing them. So, unlike a primary care physician who has to cover a lot of different things, I do care for a lot of different things that are associated with obesity, but they know the primary reason they’re coming to see me is because of their degree of excess weight. And so with that comes a little bit of a defense mechanism. They come in, and I start asking questions, “Oh, tell me about yourself. When did you first begin to struggle with your weight?”, and they give me a lot of answers that are trying to show that, “Oh, I’ve done this,” and I was like, “No, no. Just give me the story without the embellishments. I’m not making any judgment. I just want to make sure that I get the full story, so I can begin to assess what treatment modalities might be advantageous.” Often also, the person that has obesity is their own worst critic. The voice they hear in their head all the time is not mine. They spend an hour with me at their initial visit, 30 minutes for follow-up, I don’t know, three months, four months, five months down the road, but whose voice do they hear all day every day? They hear their own. And they’ve been told to believe that they’re inadequate, that they’re not worthy. That constant messaging is something that I often have to undo within the visit. So, if they go to call themselves a derogatory name, I will stop the visit and say, “I cannot listen to you hurt yourself that way. I’m going to pause. We’re going to change the language. So now, why don’t you restate this as such?” And I won’t continue the visit. You can even ask them. Will I continue the visit? I will not. Usually they want whatever we’re going to get from the visit, so they’ll say, “Okay, okay, Dr. Stanford.” And I really don’t care if you’re two or if you’re 89 - that’s the range of patients that I see, between two and 89. So, often I’m talking to people that are senior to myself, and I would say a large majority of the time I am. But for me, it’s about helping them be their best self and not comparing them to anyone else, but also helping them to undo the negative voice they hear in their head, which is born out of their lifelong experience with this disease we call obesity.

[21:29-25:47] Resources for Clinicians Seeking to Mitigate Weight Bias

Parker: Dr. Stanford, that is great. On this podcast, we wanted to highlight some techniques that clinicians can implement to mitigate their own weight bias. There are some tools which help challenge implicit racial, ethnic, and gender biases, creating awareness. So, there’s the Harvard Implicit Association Test, and there’s the Beliefs About Patients with Obesity Scale; that’s not how it’s phrased. It’s Obese Patients...

Stanford: Yes, it is! You know, you see that? Bias even in the scale; it’s so bad.

Parker: Right, right! Another study by psychologist Patricia Devine and her team developed an intervention that produced long-term reductions in implicit race bias published in the *Journal of Experimental Social Psychology*. These interventions included counter-example exposure and stereotype replacement, individualization - so looking at the whole person, perspective-taking and empathy, and even increasing contact with a certain group of people so that you can change your mindset. Additionally, in 2020, there was an article by Sara Lin and Laura Stutts in the *Journal of Psychology, Health & Medicine* that researched the exposure to counter-stereotypes in the context of obesity, which increased one’s belief about the uncontrollability of weight and decreased obesity bias. Now, we’ll put all of these articles in our Show Notes.

Dr. Stanford, are there any other resources that you might recommend for our listeners to identify and mitigate their own weight bias?

Dr. Stanford, are there any other resources that you might recommend for our listeners to identify and mitigate their own weight bias?

Stanford: Absolutely. I think one of the best resources I can think of is resources that come from Dr. Rebecca Puhl, P-U-H-L, out of the UConn Rudd Center for Health Policy. Her entire focus as the - I would say the most stellar researcher in weight bias - are all of these tools that are for clinicians, that are for other health providers that are not physicians, particularly surrounding weight bias. Even for the media, they have appropriate images for the media to access. So often, you'll notice if a story is being done if it's a television story or even if it's a print story, they will often cut off the heads of individuals that have obesity and only show from here to here. Okay. Well, that's problematic. Are we saying they don't mean anything, we just cut off their heads? Headless bodies for patients that have obesity is another way that we contribute, the media, to the stigma and bias associated with who they are and who they're not. And so, all of these resources - if you're thinking about putting together a story, thinking about looking at this - has been done really, really, very, very well with the Rudd Center.

The other place that I would look if I were a clinician is the Obesity Action Coalition. So, the OAC is a group of patients that have obesity. They're over 75,000 patients that have obesity who've decided to come together to support each other through education, through knowledge, through interaction with experts about the disease of obesity. But when you hear their voices, when you hear their voices, you get a chance to really understand what their life surrounding their disease has been like, and it's variable from person to person. Even within the same family, you can see significant variation. I always tell my patients, don't compare themselves to anyone else, unless they have an identical twin, then you can compare yourself to that identical twin. But if you don't have an identical twin, then don't compare yourself to anyone else, because you were put together differently than your brother or sister or whomever. I adore my baby sister who has always been between a size 0 and a size 2. She works out maybe - I think she may be working out now, but a little bit more, but she's like twice a year, I'm like twice a day. I've never been a size 0 or a 2. Do I compare myself to my dear sister? Absolutely not. Do I think that I'm valuable as an individual, as a human? Definitely, without being a size 0 or size 2, absolutely. And so I tell that story, and people - maybe take it with a grain of salt because I don't have obesity, but there are differences even within this same genetic milieu, same parents, same everything. I hope she gets to listen. I can't wait to show her this part, but she knows I adore her dearly.

So, these are things that I don't compare yourself to anyone but yourself. You want to be your best self, not someone else's comparator; I think that's the key thing. So, those are my resources, and that's my own personal story.

[25:47-28:14] Dr. Stanford's Final Words

Parker: Yeah, thank you for sharing. Well, Sanika and I, we really want to thank you so much for being here and sharing your expertise with us and our listeners. Is there anything else that you would want people to know about treating patients with obesity?

Stanford: Absolutely. So, I would say, first, know that you probably don't know how to treat obesity, and it's okay. The reason why we put together these modules for ACP is we knew that as internists - I mean, ACP represents over 140,000 physicians in this country, and as internists, we receive minimal training, at best, surrounding obesity. But from day one of medical school, we can start telling you how to treat diabetes. We can start telling you how to treat heart disease. We can treat a lot of very complex and - for example, almost everyone can tell you what Behcet's disease is if they're an internist. I've never seen it in real life, and you can rattle off all of the things associated with it. Obesity, which is pretty common, that's 42% of US adults, and I ask patients how to - or I ask *physicians* how to treat obesity, and they look at me with blank stares. So, there's a little bit of an issue, right? I can, immediately "Behcet's" and they're like, "Oh, yes. I have sores and ulcers and this." People get all excited, because they can then tell you about what we call that zebra, right? The horses versus zebra. If we don't know how to treat the horses, how are we going to treat the zebras? Why do we not do a good job?

So, there are resources that are available: ACP is one such resource. Be on the lookout for

horses, how are we going to treat the zebras? Why do we not do a good job?

So, there are resources that are available; ACP is one such resource. Be on the lookout for more and more resources, not only through ACP, through other - through your own personal organizations and other lectures that are out there, because this is important. You will have patients that walk through your door, or through your video cameras as we're doing a lot of telemedicine, that have obesity. You need to be the source of information. It doesn't need to be the late-night infomercial, or now daytime infomercial, about something that's unproven and can often harm our patients. They come to you. That means that we have to have the knowledge. Do the work. You can do it. The knowledge is out there. We're going to make it a little bit more available - this resource that we provide gives us, gets a little bit closer, but we have so far to go. So just keep seeking knowledge, I think, is the key thing I would say. Obesity is going nowhere anytime soon, no matter how we define it. We know it's disproportionately impacting communities of color, racial and ethnic minorities, and it's leading to poor health outcomes. We can do better for our patients. It's prudent that we do.

[28:14-29:51] Closing

Parker: Thank you for all that you've taught us and our listeners, Dr. Stanford!

Stanford: Absolutely.

Walimbe: Really interesting, thank you! Tune in to Episode 2 of this mini-series on obesity management to learn more about culturally humble and competent ways to address obesity in patients of diverse backgrounds. And you can check out all the prior episodes from The DEI Shift podcast on our website, thedeishift.com, DEI spelled D-E-I, or anywhere you get your podcasts. Thank you so much for listening!

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Special thanks to Dr. Davoren Chick, Monica Lizarraga, Dr. Charles Hamori, Dr. Tammy Lin, Dr. Tiffany Leung, and Darian Harris for helping to make this project possible.