The DEI Shift Obesity Mini-Series, Episode 2: Weight and Cultural Considerations

Transcript

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Guests: Dr. Shreela Sharma and Ms. LaToshia Rouse
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Learning Objectives:

1. Give an example of how one's culture can shape one's perceptions of weight.
2. List 3 potential questions that can be used to humbly and sensitively elicit a patient's individual and cultural perceptions of weight and their particular weight goals.
3. Compare and contrast certain cultural groups' variable receptivity to different obesity interventions.
4. Evaluate how adverse childhood experiences (ACEs) and social determinants of health can lead to obesity.
5. Describe some positive steps being taken by healthcare systems to address social determinants and improve their patients' ability to live healthy lives.

[00:00-01:11] Introduction

Jaeel: Welcome to the second episode in our special 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, to shift the way we think and talk about diversity, equity, and inclusion in the medical field, this mini-series will focus on how D-E-I impact the prevention and treatment of obesity in our patients of all backgrounds. I'm Dr. Pooja Jaeel, a combined Internal Medicine/Pediatrics chief resident and Co-Executive Producer of The DEI Shift podcast, here with my co-host…

Aradhyula: ...Likitha Aradhyula, a fourth-year undergrad at UC San Diego and a Production Assistant on The DEI Shift. These episodes are part of the ACP's new curriculum on obesity management, which you can access any time on their website at www.acponline.org. We hope you enjoy this mini-series and the larger curriculum as a whole.

Jaeel: This episode, we'll talk about culturally humble and competent approaches to prevent and treat obesity in our patients, whether we have concordant or discordant relationships with them. In other words, we as providers need to build the skill-set to help our patients manage obesity whether or not we have the same cultural background as they do. And this takes conscious effort.

[01:11-01:54] Introduction to Dr. Shreela Sharma and Ms. LaToshia Rouse

Jaeel: To help us develop these skills, we have two fantastic guests on the show today, the first of whom is Dr. Shreela Sharma. Dr. Sharma is an epidemiologist and a dietician who does work in food insecurity, obesity prevention, and health disparities research. Thank you for joining us, Dr. Sharma.

Sharma: Thank you for having me on the podcast.

Aradhyula: Our second guest is Ms. LaToshia Rouse. Ms. Rouse is a patient representative in numerous capacities, especially when it comes to maternal and infant health and patient engagement. Her contributions in these areas include bringing her perspective as a patient to the ACP Obesity Management online modules. She's also a mother of an 11-year-old and eight-year-old triplets, and she was gracious enough to join us today. So, thank you and welcome, Ms. Rouse.

Rouse: Thank you so much, glad to be here.

[01:54-06:41] Cultural Perceptions of Weight

Jaeel: So let's dive into our discussion. Just like the first episode of this mini-series, this episode could go on for hours because it's so rich and important. But we want to address some key highlights here for our listeners to take away and apply to their practice. We want to start by acknowledging the concept of weight and being over or underweight and how it can differ significantly depending on "the eye of the beholder." In Episode 1, our team discussed how obesity is defined as a diagnosis,

but different racial, ethnic, or social groups have different standards of beauty, attraction, wealth, and health. For example, even amongst the ethnic cultures represented by team members creating this episode, some cultures view what we as Western providers might call “obesity” based on BMI definitions as a quality, or even requirement, of beauty or physical appeal, or as a sign of a family's wealth or social standing and, therefore, of that family's ability to provide healthy nourishment for its members. So, starting with you, Dr. Sharma, how have you found that that really impacts your practice when you're working with your diverse patients?

Sharma: That's a really great question. Culture plays a key role; whether it’s changing dietary behaviors and obesity prevention and treatment, there's cultural perceptions around weight, and we have to also honor and understand that. We don't always want to play the role of the fixer, right? We have to understand these cultural nuances and perceptions. So for example, one of the studies we did with predominantly Hispanic families, we found that on the scale of BMI or body mass index, 40% of these preschoolers [had overweight or obesity]; parent perception of their child’s weight status was, on the other hand, 90% felt their children were of normal weight. So, the perception, which is centered around culture, “I want my child to be healthy”, right? “And as a parent, my role is to feed them.” Their basic - food is a *need*. It's not a *want* in Maslow’s Hierarchy of Needs. So, as a parent, you want to meet that basic need. Understanding all of these cultural nuances and understanding them in a positive way, so that you're working them towards their own journey about their own health goals and their family’s health goals rather than casting this, “Oh, these are barriers that we have to address.”

Aradhyula: That's a wonderful point and approach, to not view different cultural perceptions about weight as barriers but rather as assets. Another way that culture influences weight, and specifically lifestyle modifications, is that clinicians sometimes tell patients they have to stop eating certain food staples that are fundamental to the patients’ ethnic culture. For example, rice or tortillas or pasta or any number of items are integral parts of certain diets and therefore certain cultural identities. So to tell a patient they can't partake in something that's vital and a fundamental part of their traditions is a really big ask.

Sharma: As dietitians and healthcare providers, we just need to ask better questions. One of the things we know from science and literature is that knowledge, and nutrition knowledge, and just knowledge about nutrients, does not lead to actual behavior

change when it comes to improving dietary habits, and that it's really flavor and taste that are what we call important mediators of behavior change. And flavor - when you check the boxes on flavor, taste, culture, you really have improved and moved the person forward on their own journey in achieving their healthy eating behavior goals, right? So we have to ask better questions. Instead of asking, “Why don't you eat that broccoli?”, how about we ask questions like, “What kind of flavors do you like? What do you eat? And what are the spices that you like to cook with? What does your family life look like? What do your meal times look like?” And work within their own cultural nuances so that we can move them forward on their journey.

The other thing I will say is we have to celebrate culture rather than look at it as if it's a barrier. Traditional foods in fact are - across whatever culture you look at - traditional foods are healthier than the westernized diets. We know from research that when first-generation immigrants come to this country, their diets change drastically, and that, in fact, is correlated with weight gain and obesity and unhealthy dietary behaviors because consumption of what we call energy-dense, nutrient-deficient foods goes up. So that's another component, is celebrating and working with the patient to keep their traditional diet intact.

[06:41-09:39] Conversations with Patients

Aradhyula: Ms. Rouse, in your experiences as a patient, have you felt this dissonance between what healthcare providers have told you about your weight and the standards of beauty and health, or the dietary dishes, that are important to those sociocultural groups with which you identify?

Rouse: Yes. I have seen that typically, some doctors say, “This is what I eat. This is what you should eat.” I've had some doctors say, “Here is what a typical diet would look like.” They would say, “Do you like yogurt?” And I'm like, “Yes, I like yogurt.” They start telling me I should eat yogurt for breakfast. I was like, “Really?” I'm thinking soft-serve yogurt at the mall. “Are you kidding me? I can do that!” They’re like, “No, not that kind. It's the kind that’s at the grocery store in the little…” I'm like, “They don't have it in the grocery store. No, I don't eat that kind of yogurt. It's sour. I don't like that.” And so that whole discussion was derailed because I'm thinking “This is a party, I had no idea they were going to tell me to eat yogurt.” So, making sure that when we're discussing, we're talking about the same thing, because in America we call everything so many different things for the same thing. And then also having the discussion with me in a way that makes me understand

that they know my life. Questions like, “When are you able to cook? How many days a week are you cooking? Who else is in the home?” If I'm a new patient to you, you need to know that I have four children, there are more kids in my house than adults, and so, the chances of me cooking certain things are very slim, and so I would need help with that. And then, just what is a typical week like. Finding out about my life is very helpful because it's very different than a person who may have one kid or no kids or a person of a different race. I have seen a lot of times where I have gone to a doctor, and I've had that discussion *once*, so it was like, “I did it. Check. I don't need to talk to her about it because I've already discussed it.” And it's not that. If it were that easy, everybody would have the perfect BMI, and we’d be done. I've had more success when people have kept the conversation going and try to make improvements along the way instead of the one conversation that’s supposed to fix everything.

Jaeel: I like that it kind of coalesced into these simple things that we can take away, and I'm just going to try to step back to see how we can apply this. It sounds like starting off with asking questions and really trying to get an understanding of where your patient is at, both on an *individual* level - who they live with, what their routine is, all of that - and I really like what you said, Shreela, about trying to understand their *cultural* perceptions around weight and how that really impacts their view of their current weight, their lifestyle, whatever it may be. So, I love that. Starting off with first just listening.

[09:39-12:40] Culturally Sensitive Questions for Understanding a Patient’s Views on Weight

Jaeel: If both of you have any suggestions for questions specifically geared towards understanding the cultural background of a person's weight in a culturally sensitive way, it would be awesome to hear just what verbiage you use or have heard that's worked so far.

Rouse: I can say that I've had the conversation around numbers. So, “We're noticing that your weight has crept up since last visit. We also noticed that you are having to take this medication. I'm wondering if you are interested in finding out ways to reduce or eliminate the medication and also help with this situation.” And make it more about healthy than becoming a size. And then over time, I got the question of “What ideal size would you like to be? Are you at the ideal size, or is there a size you would like to be?” And so, for me, it's a 14, 16. If I get to a 14, 16, I'm going to be in a bikini on the beach. Okay? [Laughter] That's my goal. If someone says that

to you, especially an African American woman, be okay with it, because that is usually about the size. We might go further if we get there and like it, but let us be that if we want to. It's better than - if it's better than where we were, let that be the first goal. Don't try to move us down to the 6 because then I'm done, because I, in my mind, would never want to be a 6. That is not the goal. That is not the goal at all. So, understanding that can help you with the conversation. Now, I know this after doing this work: there are different types of surgeries that you can have, and having *that* conversation instead of, in my mind, you're trying to get me to look a certain way and to get down to that size, and I don't want that.

Sharma: Yeah, I completely agree with you. In addition to the ones that LaToshia pointed out, I'll just add that the couple of ones that I've found really critical when it comes to working with patients in their own journey is talking about their access to food. And not just access as, "Do you have a grocery store?" but "Do you have a stove? Do you have a microwave? What do you have at home? Can you cook? Or what does your food system and your food environment look like?" And just getting a better understanding of that.

Rouse: I would also add that if you are someone who is still working through being able to have these conversations, referrals are awesome. [Laughter] There are people who are comfortable doing that and people who specialize. I would much rather have a conversation with someone who is comfortable in doing that to get me to the next step.

[12:40-16:02] Variable Receptivity Amongst Distinct Social Groups to Different Interventions

Aradhyula: Dr. Sharma, do you find that there is variable receptivity amongst your patients of different cultures or social groups to the type of interventions that are being offered, like how receptive different groups may be to dietary changes versus exercise versus medications or surgical interventions?

Sharma: **So** certain ethnic groups respond differently. I'll give you an example specifically in regards to food insecurity. Food insecurity is chronic lack of access to food, to put it simply. And this is where the equity issue comes in because we – Hispanics and African Americans are three times more likely to experience food insecurity as compared to their white or Asian counterparts, three times more likely. That's pretty high, and it's even higher among households with children. When you think about food insecurity, that means it's also linked to what we call disordered eating,

because if you don't know where your next meal is going to come from, you're more likely to eat whatever you have in front of you because food, again, is a need. It's not a want; you need to eat to live, right? And so eating well to live well becomes a secondary issue for families who are food-insecure, right? First, it's about, "Can I fill my belly up?" It triggers what we call a disordered eating pattern, at times, where you will eat what you have when you have it, and you might eat a lot of what you have when you have it because you don't know where your next meal is going to come from. And that combination - families who are chronically food insecure have what we call spending tradeoffs in there going on. "I might have money to pay my utility bill this week but not my groceries" or "I'll pay for my groceries this week and not my rent." So we have to understand the ecosystem of food insecurity and how the family's life is affected when it's – food insecurity is a symptom of housing insecurity, of transportation insecurity, just about everything, all the social determinants of health, and that's where things start diverging because when you have certain minority groups experiencing those at much higher rates as compared to others, of course, your interventions and messaging is going to have to be different.

Aradhyula: Yes, absolutely. This fits right in with the ISMART framework for setting lifestyle modification goals with patients, which our listeners can review in the first module of the ACP online obesity management curriculum. Research has also shown that in regards to surgical interventions for obesity, men are less likely than women, and African Americans are less likely than Whites, to have considered bariatric surgery, which may be due in part to the finding that men and African Americans generally report higher quality of life scores relative to their BMI. Research has also shown that while Hispanics and African Americans are less likely to proceed with surgery than Whites, these racial differences are largely dissipated when research is adjusted for socioeconomic factors.

[16:02-20:13] Research on the Effects of Social Determinants of Health

Jaeel: So we'll move into additional things that we as providers must consider in our discussion with patients about obesity. Things like food insecurity and food deserts associated with folks of lower socioeconomic status, having a history of trauma in one's life, or living in a neighborhood with high violence or crime all play a prominent role in a patient with obesity's ability to achieve a healthy weight by the various methods that we, as providers, may recommend. Many studies have shown supporting evidence for this. One in particular is a monumental study known as the

ACEs study, which describes how adverse childhood events like abuse, domestic violence, and other stressors really increase the likelihood of developing childhood obesity that persists through adolescence and adulthood. And so I just wanted to discuss with both of you whether that's been something that you have either had experience with in the patient care world and how that factors into how you can even process the information of obesity-related education and lifestyle changes.

Rouse: I can say for me, being a person that grew up in a house where you don't waste food, if food hits your plate, you eat it, that is still a struggle to this day. If anything gets on my plate, I have to eat it all because I feel like I'm wasting it if I don't. And so even without thinking, I am a part of the "clean plate club" no matter what. I have tried to not do that with my children, but I know that it's in there, because every now and again, I say – they go, "Mommy, look. I cleaned my plate!" And I go, "I was trying not to do that, but I did it because that's what I know." Having the experience of growing up a chubby kid, we were trying not to be chubby, but we had to clean our plate - all of those confusing things that still exist for me as an adult affect how I parent my kids. That whole chain of the relationship with food, and - my father passed away when I was a child getting ready to start kindergarten so my mother surely had these concerns of having enough, and then yet, "I'm seeing this kid gain weight. How do I do this?" And so having the assistance for her would've been amazing because we probably would be in a different place, and I would be in a different place, if early on she had the support she needed to help me during that time. So I definitely identify with the study.

Sharma: I think that's so powerful, LaToshia. I mean, something that we have learned through research is that the nutrition knowledge, and all of that layers on the parenting foundation, and that is what this ACEs work has demonstrated as well, is how important and how seminal those early years are. Social support, that ongoing social support, and healthcare providers can play a big role in that because parents intersect the most with the healthcare provider in regards to their child in the first few years of life, right? So that can be a great resource in offering group education classes, like Centering Pregnancy, or support, ongoing support, so that we can establish some of those foundational pieces that then you can layer on. That's how we have tried to approach, establish early, what we call early lifecycle approach to obesity prevention. We believe it starts with pregnancy and then continues on through infancy, toddlerhood, and beyond. Pregnancy is really actually, again, literature shows and Dr. Phil Nader, my colleague who passed away, has a very

wonderful article on early lifecycle approach to obesity prevention where he talks about how when you intersect during pregnancy and infancy/toddlerhood like those two or three years, you can really break that cycle of obesity in the family because in the pregnancy, you're helping both the mom and the baby.

[20:13-23:00] Challenges that Patients and their Families May Experience with Healthy Eating

Jaeel: Something that I've noticed just in my practice is – I mean, kids are smart, they pick up on what's happening at home and the situation their parents are maybe struggling with as well. And I've had a lot of kids, especially those with chronic illnesses where they've started off young, who will ration their own insulin because they know that the family is struggling with payments and medications. And I think trying to understand their relationship with money and food together and how those intersect and factor into their idea of healthy eating is really important.

Sharma: Yeah and Pooja, you bring up a very important point that kids are astute to this and acutely aware of their environment. And the other challenge we face with processed food and junk food is that it also tastes good, right? When we talked about flavor and taste earlier, it's not a double whammy, it's a triple whammy. There's the taste component as well - it's convenient, it's cheap, and it tastes good, and that means a lot for the families who are trying to just get through the day and get your belly full.

Rouse: A lot of what we're talking about goes back to the term "social determinants of health." What does it take for a person to be healthy? When you look at all those pieces and you bring those to talk about obesity, it almost is a no-brainer. When you have people who are passing by a drive-thru after working all these hours, having to come home and take care of kids and potentially work more, there are a lot of days when the drive-thru looks very good. And then when you talk about the environment that they're in and how many fast food places do they have to pass to get home, and then you're looking at, economically, are they able to afford the private chef meals to come and be delivered to their home, the healthy ones that you know are better for you versus something else that's faster and easy to get. And then you're talking about in the healthcare environment when they're discussing the issues around obesity, how those conversations happen, and what information – how the information exchanges are happening. Are doctors and medical staff getting the information from patients that they need to help them move to the next level? And are patients getting the information that they need to

help them move to the next level, specific to that person and not the generally "this is what needs to happen;" you're getting to know that person. And then just social supports around it: "What are the people around you eating? Who is with you in your home? Who is in your family? What is your general fam and what is their diet, what is the culture? What do you do for fun?"

[23:00-26:29] Advocating For and Working Towards Health Equity

Rouse: All of that kind of stuff, it just brings me back to that social determinants. It's so important in every discipline of medicine, and I just wonder all the time, like, it would be so much cheaper if we would deal with those things that are not inside the office, the physician's office, and help support people being healthy versus the way we're doing it.

Sharma: Yes and you know, a lot of healthcare systems around the country are taking some really good strides in that and trying to make a dent in all of the social determinants of health issues that their patients are facing. Here in Houston, Harris Health, which is one of the largest safety net providers, is implementing food prescription programs for their diabetic patients, which they have a really large burden of uncontrolled diabetics. They're co-locating food pantries within their outpatient clinics. And it's free. They can take 30 pounds of food home every other week. And it's all healthy food in that food pantry. Healthcare providers to your point are thinking about partnerships outside of their healthcare system by partnering with food banks, partnering with grocery stores, giving vouchers – produce vouchers to go to grocery stores - because you want to make the healthy choice the easy choice.

And then advocacy - I think that's a very important role for healthcare providers, right? Being that advocate outside of the four walls of the clinic in whatever spaces you're in. I mean, this platform, this podcast, is an advocacy platform. So how do you train the providers to be talking about these issues in the spaces that they're in that the patient will never be? If I can be the voice for any of the patients that we work with and intersect with, that's a privilege and that's a voice that they will never have, right? So we have to - it is incumbent on each and every one of us, because what we're talking about is not food, it's not about obesity, it's not about dietary behavior. It's really about social justice in a lot of ways, and Shiriki Kumanyika wrote a phenomenal article about how we should all change our lens and think about all of this with an equity lens.

Jaeel: That was an amazing wrap-up and lessons to think about. I just wanted to reiterate what we've all talked about just in this last section was: as providers, in your bubble, I think it sounds like one of the important things is to get into this interdisciplinary group, to find out what the other people in your medical bubble are doing to further this issue and work to partner with them. So I will say, I mean on my own - our interaction with our nutritionists and dieticians are mostly through notes and EMR. So even just having these conversations in person would be really helpful. And I think in addition to the interdisciplinary team that is within your hospital - including our patients because I think they have a lot of insight into what's happening in our community that we don't - trying to figure out what other services are helping out. Food pantries, as you said, grocery vouchers - what other resources exist, and familiarizing ourselves with some of these resources so that we can pass that information on and create that dialogue with our patients. And I think the last thing was becoming an advocate and sharing these stories within our bubbles and outside of our bubbles to try to create larger change.

[26:29-28:12] Closing

Aradhyula: Well, we talked about such important cultural considerations and skills to develop in our approach to obesity management. And Pooja and I wanted to thank both of you so much for being here to share your expertise and experience with us and our listeners today!

Rouse: Thank you for having me.

Sharma: Yeah thank you so much. I really enjoyed the conversation and appreciate it.

Jaeel: If you haven't yet listened to Episode 1 of these mini-series on the D-E-I aspects of obesity management, check it out! And you can listen to all of our prior episodes from The DEI Shift podcast on our website, www.thedeishift.com. That's the D-E-I shift.com, or anywhere you get your podcasts. Thank you so much for listening!

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