Purpose

Promoting Understanding & Research into
Productivity, Obesity Stigma & Employment

Healthcare Professionals, Obesity and Employment

A guide to help healthcare professionals discuss employment with people living with obesity

Dr Zofia Bajorek and Stephen Bevan

Novo Nordisk had provided the funding to the Institute for Employment Studies (IES) to undertake the creation of the PURPOSE programme, including the production of the guide. Novo Nordisk has had no influence over the content of this guide or this programme. IES retains full editorial control over this toolkit and all aspects of the PURPOSE programme.

IES is an independent, apolitical, international centre of research and consultancy in public employment policy and HR management. It works closely with employers in all sectors, government departments, agencies, professional bodies and associations. IES is a focus of knowledge and practical experience in employment and training policy, the operation of labour markets, and HR planning and development. IES is a not-for-profit organisation.

Acknowledgements

The authors are indebted to the range of experts who we interviewed for this research, including GPs, Dieticians, Occupational Health professionals, and individuals living and working with overweight and obesity. We are also grateful to IES colleagues Rowan Munson and Steve O'Rourke for their help in producing the document for publication. We would also like to thank Dan Smith from bionicgraphics for the final design.

Institute for Employment Studies
City Gate
185 Dyke Road
Brighton BN3 1TL
UK
Telephone: +44 (0)1273 763400
Website: www.employment-studies.co.uk

Contents

Introduction

Obesity is a challenging, complex and controversial public health issue that is facing most modern, developed economies. Even though there has been some slow progress in the wider public understanding of the complex range of causes of obesity, negative stereotypes about people living with overweight and obesity persist in many environments, including the workplace and healthcare.

The health inequalities literature tells us that employment is a 'social determinant' of health. Yet, much of the mainstream epidemiological and public health discourse about obesity places little or no emphasis on the importance and benefits of good employment outcomes for people living with obesity. Employment for many can play an important role in an individual's life. It can be a key determinant of someone's self-worth, self-esteem, and a means of social participation (above and beyond material progress), and as such, could and should be emphasised in obesity treatment provided by healthcare professionals. However, evidence suggests that few healthcare professionals give sufficient priority to the employment status or aspirations of people living with obesity; and this can add to the stigma and discrimination that people living with obesity experience.

As healthcare professionals have an active role in both the prevention and treatment of obesity, it is especially important that healthcare settings and those who work in them do not reinforce stigma towards those living with obesity and help and encourage people living with obesity have the best chance to live fulfilling lives. This includes considering, where appropriate, work as a health outcome; identifying where job retention or returning to work is good for those whose obesity (and any related health conditions) are causing long-term sickness absence or work-related impairments and referring patients to specialist teams (where available) for early intervention and management.

The PURPOSE Programme

The PURPOSE (Promoting Understanding and Research into Productivity, Obesity Stigma and Employment) Programme was launched by the Institute for Employment Studies (IES) in November 2020, and focusses on the ways in which workplaces and the wider labour market for people living with obesity can be improved. The programme calls for a more concerted and joined-up approach and action by policymakers, employers, healthcare professionals, people living with obesity and wider stakeholders, to consider what more can be done to remove the current systematic disadvantage and stigma, faced by those living and working with overweight and obesity, to unlock their potential productive capacity.

This guide, the fourth output in the PURPOSE Programme, shines a light on the role that healthcare professionals can play in discussing the role of employment and employment status in the prevention, treatment and vocational rehabilitation of people living with obesity and presents guidelines and recommendations for how this can be achieved in a non-stigmatising way.

This guide will firstly outline current research highlighting the nature and prevalence of obesity stigma among healthcare professionals. Secondly it will discuss why it is important that employment is discussed in healthcare settings, and the challenges that healthcare professionals may face when talking with people living with obesity about work. The guide will then provide some tools and tips to help healthcare professionals broach the topic of employment in a non-stigmatising way. Finally, it will make recommendations from a number of stakeholder perspectives, which aim to promote more inclusive and less discriminatory practices for people living with obesity, to ensure their fair participation in the labour market.

Our Approach

To develop this guide, the authors undertook a review of the literature regarding the role of healthcare professionals, and how they consult with and treat people living with obesity. Literature into work as a health outcome, the use of language in patient consultation, obesity and employment, stigma and work as a social determinant of health was also reviewed. The authors also interviewed healthcare professionals (including, GPs and dieticians), academics who undertake research into obesity, and patients living with obesity to gauge their views on this issue and to also discuss practical and policy recommendations in this area.

Obesity and the role of Healthcare Professionals

Obesity and the role of Healthcare Professionals

Healthcare professionals (including those based in primary and secondary care, occupational health, occupational therapists, and physiotherapists, as well as healthcare professionals show may see people in workplaces) have an important and active role in the prevention and treatment of obesity. NICE clinical guidelines have previously indicated that all healthcare professionals should have a high standard of consultation skills and use a consulting style that enables people living with obesity to participate in the decisions about their healthcare, and this should take into account their culture, race and specific needs.[1]

Healthcare professionals have an important role in improving their patient's health and providing patient-centred care. Any decisions about patient pathways, management and treatment need to consider and respect the wants and needs of patients. Healthcare professionals should ensure that patients are given the support and the education to help them with their condition.

GPs are usually the 'first point of call' for help and advice for people living with overweight and obesity. Alongside practice nurses, they are the most likely to be involved in: providing advice about healthy lifestyles, updating patient health records, assessing an individual's BMI, and discussing health risks with their patients. Research has indicated that GPs have noted an increase in cases of overweight and obesity (and their associated comorbidities) in recent years; and have voiced their concerns about the implications of overweight and obesity physically, psychologically and socially. There is also evidence[2] to suggest that people living with obesity are more willing to ask GPs for counselling and information about losing weight (in comparison to other specialties); and that GPs have an important role in weight-management and weight-loss recommendations and referrals. For some GPs this is seen as an opportunity to help and positively influence their patient's health behaviours. However, for other GPs this could present a challenge.

GPs also have the opportunity to refer patients to other healthcare professionals such as dieticians, nutritionists and psychologists who can also play an important role in the management and treatment of patients living with obesity (however, this may be geographically dependent and knowledge of obesity amongst these healthcare professionals may still be limited). Such specialties are qualified to translate the science around weight regulation, energy intake and expenditure, nutrition, and behavioural techniques into practical advice that is readily accessible for people living with overweight and obesity. They can support patients living with overweight and obesity build the knowledge, skills and confidence to reach and sustain their weight-management goals, as well as linking patients to support activities in their local communities. People living with obesity may also benefit from advice supplied by nutritionists, to create tailored balanced meal plans to fit the patient's weight management goals.

Practice nurses have an important role in community settings which allows them to help identify, treat and assess patients living with overweight and obesity. They often provide lifestyle advice and information about how patients can engage with local health-related activities. There is research to suggest that practice nurses are more likely to initiate conversations about an individual's weight[3]. A common way for practice nurses to provide advice was through educational pamphlets and verbal advice, in which physical activity advice was most commonly suggested. Lifestyle advice was also offered, but there is little evidence of the provision of patient-tailored education.

How a person living with obesity experiences the care they receive in healthcare settings is extremely important as it can have an impact on the patient-healthcare professional relationship. So, what does the evidence say about the experiences of people living with obesity in healthcare settings?

[1] https://www.nice.org.uk/guidance/cg43/documents/obesity-consultation-nice-version2
[2] Teixeira FV, Pais-Ribeiro JL, Maia A (2015), A qualitative study of GPs' views towards obesity: are they fighting or giving up? *Public Health, 129 (3)*, 218-225
[3] Walsh K, Grech C, Hill K, (2019), Health advice and education given to overweight patients by primary care doctors and nurses: A scoping literature review..... *Preventive Medicine Reports, 14*

Obesity stigma in healthcare settings

The first report of the PURPOSE programme[4] signalled that alongside the rising prevalence of overweight and obesity globally, has been the pervasive weight bias, stigma, and discrimination that people living with overweight and obesity experience. These attitudes have been reported in a range of settings, including healthcare, a setting that should ideally be free of judgement, and where professionals should help rather than hinder access to support. Recent research has indicated that a proportion of healthcare professionals could be at risk of expressing both explicit and implicit weight bias at levels that are similar to the general population. A number of explanations about the sources of the stigma have been reported:

- Some healthcare professionals still subscribe to the 'eat less, do more' rhetoric of obesity, and that the causes of obesity are simplistically related to individual behavioural factors, such as inactivity, and poor or unhealthy eating habits. This attitude implies that the person living with obesity is at fault or responsible[5]. This attitude could also lead to an over-emphasis on the volitional nature of obesity, which can sometimes be accompanied by an underrepresentation of other factors such as social deprivation of genetics. There is still also a debate among healthcare professionals regarding whether obesity is a disease.
- Related to their understanding of the causes of obesity, a significant minority of healthcare professionals hold the common stereotypes that people living with overweight and obesity are lazy, unwilling, and unmotivated to lose weight, and they lack self-control[6]. Healthcare professionals holding these views may therefore believe that people living with obesity are not capable of losing weight, and as such could display little satisfaction in providing them with care.
- Research[7] has suggested that a number of healthcare professionals do not believe that patients will be successful in managing their weight through lifestyle changes. This can potentially result in stigmatising advice given to patients, and unrealistic discussions and expectations about the weight that could be lost.
- Obesity has been seen by some healthcare professionals as a non-medical issue[8]. This perspective had negative consequences on: their motivation to treat obesity, on their ability to the issue seriously, and on the attitudes they showed towards people living with obesity.
- The practical set-up of clinical settings can themselves be stigmatising. Healthcare professionals may not have the clinical equipment[9] to measure weight or blood pressure of people living with obesity, and reception seating areas may be inadequate or inappropriate meaning that people living with obesity feel uncomfortable or embarrassed about attending clinical appointments.
- Patients living with obesity have experienced healthcare professionals attributing health complaints to their obesity, even when the reason for their appointment was in no way related to it[10]. These experiences were often partnered with what they felt to be degrading or moralising attitudes towards them, and a sense there was 'little treatment time' or enthusiasm around the treatment they received.
- Patients have also reported levels of insufficient engagement from some healthcare professionals throughout their consultations, often shown through limited enthusiasm to speak to patients, limited attention, and even the provision of contradictory advice[11]. The research exploring patient experiences also suggested that some healthcare professionals may have displayed frustration, assumed that patients have limited motivation to lose weight, rushed patient consultations, and failed to prioritise regular consultations to assess change and monitor treatment approaches.

[4] https://www.employment-studies.co.uk/system/files/resources/files/Obesity%20Stigma%20at%20Work%20_0%20Improving%20Inclusion%20and%20Productivity_0.pdf
[5] Teixeira FV, Pais-Ribeiro JL, Maia A (2015), A qualitative study of GPs' views towards obesity: are they fighting or giving up? *Public Health*, 129 (3), 218-225
[6] Texeira FV, Paid-Ribeiro JL, Maia AR (2011), Beliefs and practices of healthcare providers regarding obesity: a systematic review. *Revista da Associacao Medica Brasileira*, 58 (2), 254-262
[7] Phelan SM, Burgess DJ, Yeazel MW et al (2015), Impact of weight bias and stigma on quality of care and outcomes for patients with obesity, *Obesity Review*, 16 (1), 319-326
[8] Gunther S, Guo F, Sinfield P et al (2012), Barriers and enablers to managing obesity in general practice: a practical approach for use in implementation activities, *Quality in Primary Care*,20 (2), 93-103
[9] Phelan SM, Burgess DJ, Yeazel MW et al (2015), Impact of weight bias and stigma on quality of care and outcomes for patients with obesity, *Obesity Review*, 16 (1), 319-326
[10] Malterud K, Ulriksen K (2010), Obesity in general practice: A focus group study on patient experiences. *Scandinavian Journal of Primary Health Care*, 28 (4), 205-210
[11] Flint SW (2015), Obesity stigma: Prevalence and impact in healthcare, *British Journal of Obesity 1*, 14-18

- Communication is often viewed as an important aspect of clinical appointments[12] [13]. There is evidence suggesting that some healthcare professionals communicated in a less patient-centred manner with people living with obesity and spent less time providing education about the condition, and failed to offer or refer people living with obesity to other treatment option (often as a result of insufficient knowledge about services available for the treatment of obesity). Some patients living with obesity reported interpreting silence in treatment settings as physician disapproval.
- Obesity stigma in clinical settings was found not solely in the domain of GPs, but also identified among nurses, dieticians and psychologists[14]. Reports[15] have provided evidence showing that some nurses thought that obesity was preventable, and that people living with obesity lacked motivation and compliance to treatment. It was also found that dieticians may have displayed ambivalent attitudes towards people living with obesity, and considered weight issues to be associated with emotional problems. In the research, some psychologists also tended to rate people living with obesity more negatively on their appearance.
- Studies have explored when in a clinical career stigma towards people living with obesity occurs. Research has indicated that a number of medical students already show some negative bias towards patients living with obesity, rated them less favourably, and used derogatory humour[16]. There is also some research suggesting that younger healthcare professionals could show more bias towards people living with obesity then older or more experienced professionals.

The implications of obesity stigma for patient outcomes

Previous research into the nature and consequences of stigma for people living with obesity has highlighted the negative implications it can have for both individual physical and mental health. Research has also shown how stigma can encourage the development of maladaptive coping responses. There is an accumulation of the evidence describing the negative consequences of the stigma experienced in healthcare settings:

- When people living with obesity perceive that they have been criticised or dismissed by healthcare professionals in clinical settings, they may display a reluctance to address their concerns, and they may avoid, delay or cancel subsequent appointments[17], which could result in further health inequalities.
- Other maladaptive coping responses that have been recounted include a reduction in health seeking behaviours, less trust and re-assurance in patient-clinician appointments, not attending medical screenings, and potentially impeding treatment by changing doctors frequently[18].
- If people living with obesity do attend appointments, they may refuse any physical examinations. This refusal could have an impact on the diagnosis of any comorbid health conditions.
- If clinicians do not recognise obesity as a disease, then they may also be sceptical about the effectiveness of any treatment, or management pathways. This could mean that they do not refer people living with obesity to specialised practitioners[19]. This could further exacerbate their obesity, or they may miss diagnosing any associated comorbid conditions.
- Clinicians who display weight-stigma may also hold shorter patient consultations, show less effort with patients living with obesity, and display interpersonal avoidance[20].

[12] Phelan SM, Burgess DJ, Yeazel MW et al (2015), Impact of weight bias and stigma on quality of care and outcomes for patients with obesity, Obesity Review, 16 (1), 319-326
[13] Puhl RM, Phelan SM, Nadglowski J, Kyle TK (2016), Overcoming weight bias in the management of patients with diabetes and obesity. Clinical Diabetes, 34 (1), 44-50
[14] Flint SW (2015), Obesity stigma: Prevalence and impact in healthcare, British Journal of Obesity 1, 14-18
[15] Budd GM, Mariotti M, Graff D, Falkenstein K (2011), Health care professionals' attitudes about obesity: An integrative review. Applied Nursing Research, 24, 127-137.
[16] Phelan SM, Dovidio JF, Puhl RM et al, (2014), Implicit and explicit weight bias in a national sample of 4,732 medical students: the medical student CHANGES study. Obesity, 22 (4), 1201-1208
[17] Flint SW (2021), Time to end weight stigma in healthcare, EClinicalMedicine, 34, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8042345/pdf/main.pdf
[18] ibid
[19] Texeira FV, Paid-Ribeiro JL, Maia AR (2011), Beliefs and practices of healthcare providers regarding obesity: a systematic review. Revista da Associacao Medica Brasileira, 58 (2), 254-262
[20] Jung FUCE, Luck-Sikorski C, Wiemers N et al (2015), Dietitians and nutritionists: Stigma in th e context of obesity. A systematic review, PLOSOne, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4605484/pdf/pone.0140276.pdf

Other barriers faced by healthcare professionals

Stigma from healthcare professionals is an important barrier that people living with obesity have to overcome when accessing obesity management and treatment pathways. Another barrier is the variation in the provision of weight management services across England, and the way in which obesity services are commissioned. The current weight management pathway in the NHS is based around 4 tiers:

- **Tier 1:** These are universal behavioural interventions, including public health and national campaigns that provide brief advice. Individual local authorities are responsible for the commissioning of these services. The services in this tier are delivered by local and regional public health teams, and often carried out in primary care settings.
- **Tier 2**: This tier is based around lifestyle weight management services, which are usually time limited, and which are commissioned by local authorities. These services are delivered by local community weight management services, and are based around nutrition, lifestyle, diet and behaviour advice, normally provided in group setting environments.
- **Tier 3:** At this level people living with obesity can receive treatment from clinician led multidisciplinary teams (including specialist dieticians, specialist nurses, psychologists, consultants with a special interest) in specialist weight management clinics providing non-surgical intensive medical management. Local commissioning groups are responsible for commissioning these services.
- **Tier 4:** When people living with obesity reach tier 4, then surgical or non-surgical bariatric surgery is available to them, supported by a multi-disciplinary team, pre and post-surgery. Local commissioning groups are responsible for commissioning these services.

However, evidence suggests that inequalities in accessing these services exist, and people living with obesity may not have access to the appropriate level of support at the appropriate time[21]. Local authorities and commissioning groups make decisions about what weight-management services they fund, and as a consequence of budgetary constraints, there is regional variation in the level of services provided.

As a result of how these weight management services are structured, there can be a lack of flexibility within the patient pathway and, as commissioning budgets are also from different sources, it becomes even more difficult for patients to transition smoothly between the tiers. It has been observed that people living with obesity have to 'jump through unnecessary hoops' to reach the services that will best suit them, meaning that they may have delayed access to the most relevant treatment approach. This delayed access furthers patients' risks to obesity-related ill-health and the development of any obesity-related comorbidities.

Discussions with clinicians for this research also highlighted that training and teaching about obesity is minimal and not appropriately covered in medical schools. Clinicians, especially GPs, may not have a full understanding about the causes of obesity, and the consequences that living with obesity can have on a person's life. Many clinicians do not know what weight management services are available locally and have not been trained to raise and discuss obesity in an appropriate way with patients. As discussed above, even if clinicians do talk about obesity and want to refer patients to appropriate care pathways, these may not even be available to them.

Of course, health related outcomes are not the only ones of importance for people living with obesity. Among a range of quality-of-life outcomes include the ability to find and sustain good quality fulfilling and inclusive employment. Yet work-focused conversations in clinical settings are by no means a routine part of care pathways or shared decision-making for people living with obesity in either primary or secondary care. The remainder of this guide focuses on

[21] https://static1.squarespace.com/static/5975e650be6594496c79e2fb/t/5fbe2a92e18c5c478ec569a0/1606298265632/Obesity+APPG+-+The+Future+of+Obesity+Services.pdf

why might be important for people living with obesity to be able to discuss aspects of their working lives with a healthcare professional whether in a dedicated healthcare setting, or with an occupational health (OH) professional or allied health professional (AHP) in a workplace environment.

Why discuss employment?

Why discuss employment?

Work can be good for health

For many people, their employment can be a key determinant of identity, self-worth, self-esteem, the provision of opportunities for material progress and also a means of social participation[22]. There is now also an accumulation of evidence suggesting that work can be good for health, especially if people have access to 'good work'. 'Good work' is often defined by having positive workplace factors including: a balance between effort expended and the rewards gained for their work; how well employees are managed and supported at work; employee 'voice'; the level of social interaction and social support an employee receives in the work environment; an employee's opportunity to develop and learn at work; the level of job security their work offers, and the amount of control, autonomy, discretion and variety of work that employees have over their roles. If people experience good work, then the benefits of employment can outweigh risks, and can be better for an individual in comparison to long-term worklessness or prolonged sickness absence.

Work can have an impact on obesity

Although there is evidence highlighting the role that 'good work' can have for an individual's psychosocial health, there is also evidence to suggest that someone's experience at work can have implications for their overweight and obesity. This suggests that it is important to gain an understanding of a person's work and their work history to gain a wider perspective of the role of work in their lifestyle and whether returning to work or remaining at work is a goal for them. There is also an important role for Occupational Health to understand what issues may arise at work and to aid organisations in the design of any workplace health promotion programmes or interventions.

There are a number ways in which the workplace environment and the way that work is designed can have an impact on obesity[23]. These include:

Shift work
Employees in various employment sectors are expected to work unconventional hours or shift patterns which can have implications for obesity. This can be as a result of changes in biological rhythms, sleep patterns, social isolation, and because of the type or availability of food available on night shifts. For example night shift workers may increase their consumption of sugary or caffeinated food and drinks to help combat tiredness, and/or there may be limited availability of 'healthy options' during their working hours.

Working hours
The number of hours employees work a week has been associated with weight gain, especially if the employee is based in a hostile work environment. Women, in particular, have been shown to report higher levels of weight gain when they have worked increasingly longer working hours. There is evidence that elderly employees who work over 59 hours a week has a 30% increased likelihood to gain weight (in comparison to those who worked fewer hours).

Sedentary behaviour
It has been argued that technological adaptations to the workplace have been associated with increased sedentary behaviour in some sectors. Tracking of occupational physical activity and energy expenditure have suggested that changes in sedentary behaviour recorded could account for some weight gain in employees.

Psychosocial work factors
The way that employees interact with others in the workplace has been associated with obesity. For example, poor interpersonal treatment had implications for increased depression and/or stress for individuals, in turn resulting in altered eating patterns. Experiencing harassment at work (from either colleagues or management) has also been associated with obesity. Those

[22] Working for a healthier tomorrow - Dame Carol Black's Review of the health of Britain's working age population (publishing.service.gov.uk)
[23] https://www.employment-studies.co.uk/system/files/resources/files/Obesity%20Stigma%20at%20Work%20-%20Improving%20Inclusion%20and%20Productivity_0.pdf

with low levels of autonomy and high demands and job pressures reported fewer opportunities for breaks, which had implications for the type of food chosen and the pace with which it is eaten and an increase in snacking or the consumption of 'comfort food'.

The impact that working with obesity can have for employment
The weight-stigma that people living with overweight and obesity experience in society and through the media is also present in the work environment. Weight-based stigma in employment is pervasive and occurs at every stage of the employment cycle:

Recruitment and selection
Research has indicated that employers predominantly view overweight and obesity as within an individual's control. This view results in the common stereotypical beliefs that people living and working with obesity are lazy, less conscientious, incompetent and will have higher levels of sickness absence. Consequently, this research indicated that people living with obesity were less likely to be considered suitable for recruitment. There is also evidence to suggest that people living with obesity are not selected for certain roles if they do not 'fit' into an organisation's representational image or have physical limitations that meant they would be not as productive in a role. Importantly, these beliefs were not based on somebody's actual competence and ability, but on employer's perceptions on what someone living with overweight, or obesity will be able to achieve. Employers displaying weight-based stigma at this first stage of the employment cycle could lead to an increased potential for further in-work stigma and discrimination, and unemployment.

Wage penalty
There is now an overwhelming evidence base showing that women living with obesity experience an 'obesity wage penalty'. Quantifications of this wage penalty have estimated that this can range between 0 and 20 percent, with a consensus that an 8 to 10 percentage gap in average earnings is most likely. This finding does not only apply to annual earnings figures, but there is also evidence of a strong cohort effect. The obesity wage penalty can represent a considerable financial cost to individuals and their families, as well as perpetuating exiting inequalities.

Employee relationships and wellbeing
Employees living and working with obesity have often discussed feelings of isolation and 'being shamed' in the workplace. This potential lack of support from both managers and colleagues that they experience can lead to reduced wellbeing, increased stress, and maladaptive coping responses.

Promotion and progression
Obesity stigma can also have implications for promotion and progression (once again specifically among women living and working with obesity). Performance appraisals, which are usual mechanisms for determining progression, pay rewards, and access to training and development can be subject to intended or unintended weight-based stigma, which may therefore be detrimental for people living with obesity in employment.

Retention and unemployment
Finally, employees living with obesity may be more at risk when strategies about employee retention are discussed. Research has highlighted evidence of discriminatory termination of employment contracts that were because of weight-based decisions (or perceived attractiveness) rather than on performance in the role or role-based evaluations. Evidence has also suggested that those living with overweight or obesity may be at greater risk of unemployment.

It is for these reasons that discussions about employment with healthcare professionals could be important to raise in patient consultations or during the treatment pathway, especially if employment is an important for the individual. But do these conversations happen, and what can be done to help healthcare professionals engage in employment discussions for people living with obesity?

Do healthcare professionals engage in employment-based conversations?

Do healthcare professionals engage in employment-based conversations?

In a recent report by Public Health England (2019)[24] it was found that most healthcare professionals do not engage in work-based conversations with their patients. Several reasons for this were offered as an explanation of this finding:

- Healthcare professionals have reservations about the acceptability of discussing work, or work-based decisions and issues, when they may not be part of the patient's agenda.
- It has also been observed that work-based conversations may not always be appropriate, and as such could be counter-productive if they are not well-informed, evidenced and consistent messaging or support cannot be given throughout patient management.
- What a good or supportive work-focused conversation is in routine healthcare settings has not been defined or established. Just raising the issue of work in a clinical encounter is not considered to sufficient, and more understanding about the content and the quality of work-based conversations is necessary.
- Clinicians have voiced hesitancy regarding when in the treatment process the topic of work should be raised. At the moment it is usually based on individual clinical judgement and/or patient needs or circumstances.
- GPs, in particular, perceived that their role was limited to providing management and support for health-related issues and they felt inadequately informed to offer occupational advice to their patients. Additionally, some GPs did not raise employment to avoid patient expectations about the 'fit note'.
- The provision of training about how to discuss and understand work issues among healthcare professionals is limited, as there is the assumption that occupational health would cover such conversations.
- Healthcare professionals also have a reluctance to initiate an employment conversation if they feel that they can do little to change the situation.
- Concerns also existed regarding patient hostility or defensiveness about their employment situation, which could hamper further patient conversations.
- There is still a fallacy that promotes the idea that illness is incompatible with employment, and that individuals should only be at work if they are 100 percent fit. This thinking still underpins the approach to treatment undertaken by healthcare professionals.

[24] Work Conversations in Healthcare - How where when and by whom (publishing.service.gov.uk)

Policy interventions to help professionals discuss employment

Policy interventions to help healthcare professionals discuss employment

Healthcare professionals' consensus statement

In Dame Carol Black's report[25]the healthcare professional's role was seen as 'key' to providing much of the support that people need to stay in or return to work as a result of the advice they can provide and the influence they have in helping a person realise their ability to work, and what is available to them to achieve this. The role of the GP was described as particularly important as they are usually the first point of contact when a patient needs advice about their fitness for work, and their advice can have an impact on the next steps a patient may take. But as noted above, there are a number of barriers that healthcare professionals perceive to having these conversations. The report included a consensus statement from leaders of a variety of healthcare professions, to demonstrate a commitment to promote a link between good work and good health, and affirm their role in supporting patients to remain in or return to work. This was seen as a step forward in this agenda.

Work as a health outcome

The Joint Work and Health Unit developed a 10-year strategy to improve employment outcomes for working age people with long-term health conditions or disabilities. Part of this strategy included implementing 'Work as a health outcome', seeking to promote healthcare professionals' understanding of the health benefits of good work, and supporting healthcare professionals to have conversations about work and health. This strategy was not asking healthcare professionals to be experts or specialists in employment support, but asking them to initiate conversations about work, and to prompt patients to seek and engage support from other sources. Part of this included updating the consensus statement for health and work, which was launched in 2019[26].

The consensus statement includes several ways through which healthcare professionals can work together with patients as an integral part of the care pathway. These include:

- Creating a culture where good work is seen as a benefit to people;
- Helping to promote the aspiration of working in patients;
- Promoting healthy life choices and lifestyles;
- Discussing, where relevant, health risks, hazards, and any adaptations in working environments;
- Providing support to help patients enter, remain and/or return to work when they are ready and enabled to;
- Helping patients to access high quality sources of specialist support to enter or remain in work; and
- Contributing to reducing the social discrimination, harassment and victimisation associated with ill-health or disability, both physical and mental.

[25] Working for a healthier tomorrow - Dame Carol Black's Review of the health of Britain's working age population (publishing.service.gov.uk)
[26] https://www.rcn.org.uk/news-and-events/blogs/linking-work-and-health-the-role-of-nurses

Alongside this, the consensus statement also included four principles for all healthcare professionals to commit to and act upon over the next five years to engage more with work as a health outcome across the health and care sector.

The four principles were to:

1. Understand the health benefits of good work, and the long-term effects of avoidable health related worklessness;
2. Have the skill to incorporate discussions about working in the context of a health outcome with patients in their care, as appropriate to the health or disability of that individual;
3. Feel supported to understand and interact with the wider health and work system including employers, occupational health services, and other bodies that have a role in assisting individuals who are not working for health-related reasons;
4. Recognise their own role to support healthy and safe working environments, including looking after their own health and wellbeing and those of their colleagues.

An evaluation of the 'work as a health outcome' pilot found that although there has been progress in understanding its importance, 'health' and 'work' services are still felt to operate separately and there is need to work more collaboratively. The consensus statement was well received, but success has been more in raising awareness of work as a health outcome, rather than galvanising action as a result of its limited practical advice which may not engage primary care clinicians who may not know what action to take.

A pilot also occurred trialling health and work medical champions to increase capacity and appetite for the integration of health and work advice in clinical practice. The pilot helped to provide healthcare professional training, built relationships between primary care settings and JobCentre Plus, and started to create a common voice around the key messages of the work as a health outcome agenda. However, it is recognised that GPs are gate keepers to discussions about work and health. GPs described not having the time, capacity or knowledge to engage with any employment related issues that a patient may be experiencing. Practitioners referred to their competing priorities and so were unsure about how to support the proposed agenda, especially because the system was still viewed as complex and fragmented. There was evidence to suggest that there is an appetite for joint working in this space, but more training and support is needed in this area.

Given the difficulties that have been reported in discussing work in clinical practice, and the bias and stigma that healthcare professionals have when treating people living with obesity, it is clear that guidance is required to help healthcare professionals consider work as health outcome for people living with obesity.

Guidelines for Healthcare Professionals

Guidelines for Healthcare Professionals

In other lifestyle choice conversations (e.g. smoking cessation) that healthcare practitioners (primarily GPs) have with patients, the '5 As' have been developed, and these have since been adapted for discussions around obesity[27]. However, any current guides or tools helping healthcare conversations address obesity management still do not include the important aspect of employment.

As discussed above, there are similarities in the barriers to starting conversations about both employment and obesity but using the 5 A's approach can help healthcare professionals with this.

Ask

Both weight and employment status can be sensitive and stigmatising issues for people living with obesity, and healthcare professionals need to be aware of how they broach these topics in clinical settings. It is therefore suggested that healthcare professionals ask for permission to discuss weight and employment. This is especially the case if the patient has an appointment with a healthcare professional for another health matter.

Asking for permission helps to reduce any judgement or blame that could reduce the effectiveness of any further discussion about both topics. It also leads to effective communication without making any assumptions about their behaviours or lifestyle. An important part of asking the question is assessing a patient's readiness to manage their weight, and potentially any other aspects of their lifestyle. By asking permission to talk about weight, a healthcare professional is also indicating their willingness to listen to their patient's responses, to respond in a way that highlights that they have acknowledged what has been expressed, and to work with their patient to address these issues.

Language is important here. Sample questions can include:

- "Would it be alright if we discussed your weight?";
- "Would you be interested in addressing your weight at this time?"; or
- "I would like to ask you some questions about your lifestyle which may include your weight? Is that ok? Feel free not to answer these questions if you don't feel ready to."

However, if you are going to ask these questions, it is important to display empathy and understanding. A patient may have had a difficult conversation with a healthcare professional previously which resulted in them feeling uncomfortable or reluctant to seek further guidance. If the issue is to be addressed, then it is also important that enough time is given to the discussion. It may be more appropriate to book another appointment to ensure that a helpful consultation can be provided, which may include taking a weight history, showing empathy and freeing patients from some of their concerns, and potentially (if they want it) help people onto a weight-management pathway.

With regards to employment, as part of the registration process, employment status and work-related information could be obtained. If a weight history is taken, then this could be mapped against life events, where employment is considered. At this stage, it is still necessary to ask whether they are willing to discuss their employment status or whether there has been a change to their recorded role, to reduce barriers to these conversations. It could also be helpful to explain that this information is helpful to highlight how any work-related issues can contribute to their health and any potential recovery and management pathways. This explanation may encourage the patient to disclose any work-related matters that could be having an impact on their weight, and/or other comorbid conditions.

[27] https://d3j7puhwqgd8ts.cloudfront.net/Uploads/r/y/q/finalobesityalgorithmwithreferences_771631.pdf

Assess

The ask stage has hopefully resulted in healthcare professionals gaining some important information that they need from their patient to enable an informed assessment of the related risks and potential root causes of weight gain. To ensure this is done is a non-stigmatising manner, healthcare professionals need to consider a health-centred rather than weight-centred assessment.

This can include:

- Discovering what the patient's ideas, goals and concerns are;
- Understanding what their reasons for attending a medical consultation are;
- Taking a full weight history including any previous weight-management programmes and their outcome; and
- Talking about any recent weight changes and what the triggers to these may have been.

Health assessments should also be undertaken during this stage. This includes measuring a patient's BMI to understand the severity of their obesity, a measurement of waist circumference which could be an indication of cardiometabolic risk, and the Edmonton Obesity Scale could be used to assess the functional impact of a person's obesity.

An assessment of the root causes of obesity should also be undertaken, and these could be inter-related and multi-factorial. The root causes may be:

- Metabolic – related to age, genetics, hormones, medication;
- Mental health related – emotional eating, weight-based stigma, mental health medication; or
- Lifestyle related – Socio-cultural factors, socio-economic factors, employment, obesogenic-environment

When it comes to discussing employment, healthcare professionals are not expected to have a specialist knowledge about how work can have an impact on an individual's weight, but during this assessment stage they could ask questions to understand how work is affecting a patient's weight, and how their weight is affecting their work. Questions could include:

- "Do you think your work has an impact on your weight in any way?";
- "How does weight have an impact on your work role?"
- "What tasks can you manage at work and which do you find difficult because of your weight?"; or
- "Are there any ways on which your employment enhances your health and weight?"

The questions and assessments made at this stage will help both the patient and the healthcare practitioner to openly discuss any specific areas of concern and benefits regarding their employment and their obesity, and to consider how this will fit in with any weight management plans.

Advise

Having gone through the previous stages to develop a collaborative relationship with the person living with obesity, gained an understanding of their weight history, their employment status (and employment role and activities) and established a sense of trust, the next step is to ask permission to offer advice and a clinical management plan. This can be undertaken in a non-stigmatising way, by explaining that weight regain is driven by biological mechanisms (and not laziness or lack of willpower), and so long-term weight-management is essential. An individual

may have their own personal goals they would like to achieve, and they should be empowered and helped to try and achieve them.

Weight management plans can be dependent on a number of factors, including: changing medication if that was a cause of weight gain; referring patients living with obesity to counselling services if there are comorbid mental health issues; and in light of disease severity, complications as a result of comorbid conditions. The availability of local weight management services must also be considered when discussions about next steps are to occur.

If returning to or remaining in employment is part of the patient's goals, then a person's employment can also be included in this stage, and work could be included as a health outcome. Healthcare professionals need to understand that living with obesity (and related comorbid conditions) does not mean that individuals are unable to work or perform their roles. These individuals may, however, need advice about what workplace adjustments may be helpful for them to enter or remain in employment, or advice about how to discuss their obesity with Occupational Health practitioners.

Agree

If a weight-management plan is going to work, then it must have patient buy-in, and goals and any course of action needs to be agreed. This may require multiple conversations so any arrangements can be modified to ensure that people living with obesity are comfortable with what is being suggested. As a result of this agreement, appropriate and realistic targets and goals can be discussed with each patient, which may require referrals to both local services and specialised management services. If employment has previously been mentioned or discussed, then work as a health outcome can be included in these goals.

As previously discussed, the current weight management system in the UK is based on a tiering system that people living with obesity are referred into, which at lower tiers are focussed on local support services (where possible) and commercial weight management programmes. When it comes to tier 3 and specialist weight management services, this could be where employment is taken into greater consideration, but once again, only if this is an agreed goal in the patient's weight management plan. In the initial sessions with a medical specialist, the aim for healthcare professionals is to broker the patient-practitioner relationship and to sensitively take a weight history, which at this point may or may not include employment. What is discussed is patient led, and what is most important to mention thus varies between patients. Specialist weight-management nurses who could provide advice about how to connect employment into any weight-management services and treatment are rare, and location dependent but could be an important resource to help with these discussions.

Assist

Once a treatment plan has been agreed, it is important that healthcare professionals assist people living with obesity to recognise what barriers there may be to achieving these goals, and what could help motivate and facilitate them. Follow up appointments can be made to support patients, to understand if they are responding to treatment, to understand if further modifications to treatments are necessary, or to decide if the patient requires a referral to another tier.

There are a number of discussions that healthcare professionals can assist with in regard to employment. For example, if healthcare professionals understand the patient's work role and any limitations that working with obesity can have on this, discussions could be based around identifying what appropriate workplace adjustments could be made that could allow someone to continue or return to work. In the workplace some of these adjustments are undertaken by the line manager, and healthcare professionals could suggest ways through which the patient could start such discussions with their line manager.

Fit notes are a tool that GPs can use to help provide fitness for work advice to patients. If a patient living with obesity (and/or comorbid conditions) would like to return to work, then GPs can play a key role in advising their patient about returning to work, help patients develop a work plan, and can facilitate a return to work through shared decision making. The fit note is a tool that can capture a GPs advice for both the patient and the employer, thereby allowing for an effective conversation between the employer and patient to accommodate a return to work, or work adjustments. However, this will have to be completed in a non-stigmatising way for people living with obesity, and GPs should recognise that the workplace can be a stigmatising environment for people living with obesity, so these concerns also must be taken into consideration.

Assistive and supportive behaviours need to be displayed for people living with obesity who are starting weight management. This is especially important for those who are referred to tier 4 and are discussing bariatric surgery. At this stage, people living with obesity may have faced significant barriers or disappointments with treatments at previous tiers, and so will need to be provided with realistic expectations about the weight loss they could achieve. Patients may have a number of concerns about surgery and should be provided with the opportunity to discuss the pros and cons with multi-disciplinary teams. For those in employment receiving bariatric services, any conversations that patients have about employment are concerned about the length of time they would require off work so they don't have to tell their managers what they are taking time off for. However, patients must be aware of the challenges they may face after surgery, including nutritional supplements, mental health concerns and problems with body image that would need to be reviewed. These could also have implications for returning to work or result in work-related issues that healthcare professionals may need to further assist with.

Language Matters

Healthcare professionals must be aware of the language that is used when speaking with patients. People first language (eg putting people before a characteristic of disability) should be used in conversations with patients. For instance, rather than using "obese people are more likely to", using people first language would be "people living with obesity are more likely to". Labelling individuals with their disability or disease is seen as dehumanising, and using people first language is now becoming more common in other chronic conditions. Obesity should be given the same respect as other diseases.

Other language considerations should also be made in consultations as this will have an impact on how comfortable people living with obesity will be when discussing their weight[28]. Research has indicated that people living with obesity preferred terms such a 'weight', 'overweight', whilst being named 'obese', 'larger size' and 'fat' and having 'excess fat' was least preferred. These least preferred terms were associated with stigma and blame, and they elicited feelings of sadness, contempt, anger and disgust in research respondents[29]. Using medicalised terms, however are more accepted among people living with obesity. Healthcare professionals should become more conscious about the language that they use, to avoid further stigmatising patients who may already feel vulnerable in clinical settings.

[28] Albury C, Strain WD, Tahrani AA (2020), The importance of language in engagement between health-care professionals and people living with obesity: a joint consensus ..... statement. The Lancet Diabetes and Endocrinology, 8, 447-455

[28] Brown A, Flint SW (2021), Preferences and emotional responses to weight-related terminology used by healthcare professionals to describe body weight in people living ..... with overweight and obesity. Clinical Obesity. Available at: https://onlinelibrary.wiley.com/doi/epdf/10.1111/cob.12470

Recommendations

Recommendations

Healthcare professionals have an important role in both the prevention and treatment of overweight and obesity. Consequently, being able to consult and advise patients without adding to their feelings of stigma and discrimination is vital for both the patient-healthcare professional relationship and the successful development of weight management plans. However, it is also known that employment, especially 'good employment' can have positive therapeutic benefits for individuals and could be a determinant of individual health, but healthcare professionals currently place little or no emphasis on the employment status or aspirations of people living with obesity.

The evidence and the guidelines presented here illustrate that the 5As model that was developed to promote patient behaviour change can be adapted to both help healthcare professionals discuss obesity in clinical settings, and to include ways in which issues and advice around employment can be given. However, for these discussions to occur effectively, there are systemic barriers that must also be addressed.

The PURPOSE Programme has therefore developed a number of recommendations for a range of stakeholders in this area. While it is acknowledged that obesity is a challenging and complex public health issue, the level of stigma and discrimination that people living with obesity experience in healthcare and employment settings highlights that more can be done to improve both their health and employment outcomes, and that more still needs to be done to promote more inclusive practices within the UK. Below are some steps that key stakeholders can make to recognise that more still needs to be done to develop both less stigmatising healthcare practices, and improved labour market participation for people living with obesity.

Recommendations for Government

- Obesity needs to be recognised as a disease in its own right. As has occurred with other chronic conditions, once a condition is classified as a disease this changes how obesity is treated, funded and prioritised. For example, if obesity is designated as a disease then it will become much easier for the NHS to develop a National Service Framework so national standards and key interventions can be set, and the development of clinical guidelines and care pathways, clinical audits and commissioning protocols can occur so that there is equal service provision across the UK.
- Better measures are needed to assess the social, economic and work implications of obesity to allow NICE guidelines to take these into account when they are evaluating treatments and therapies through Health Technology Appraisals (for example bariatric surgery). Changes to the NICE approach would allow them to take societal perspectives into account and calculate the benefits of full and active labour market participation.
- We welcome the recent Obesity strategy and the announcement on World Obesity Day 2021 regarding new specialised support systems to help those living with obesity. We further welcome the £70 million being invested into weight management groups, and that the investment is being split between local authorities and NHS services (which include clinical support). However, we believe that the strategy could go further:
    - » Improving the commissioning of Tier 3 and Tier 4 services across the UK so everyone has equal access to the necessary support and leading to improved referral from Primary Care.
    - » Measuring work status as an outcome measure in both clinical trials and patient interventions.
    - » Embedding the principle that work must be a priority clinical outcome of care.

  - » Rethink the way that weight management services are structured, allowing for greater flexibility within the patient pathway, reducing the delays that people living with obesity currently experience gaining access to Tier 3 and Tier 4 services. A simplified system which allows people living with obesity to enter and exit the pathway at the appropriate level should be developed.

  - » The voice of people living with obesity in shaping treatment pathways and the evaluation of government policy relating to obesity needs to be included.

- There needs to be improved co-ordination and joined up working between policy makers across Whitehall, and the devolved administrations, to make it easier to share innovations, good practice regarding obesity and employment, and any data that highlight interventions to improve both the health and labour market outcomes for people living with obesity.
- Although the obesity strategy mentioned consultation with employers about obesity and the workplace, this could be further extended to undertake research into the prevalence and causes of obesity stigma in the workplace, and into incentivising employers to introduce evidence based workplace support to help people living and working with obesity.

Recommendations for Professional Bodies

- Work as a clinical outcome should be embedded in the healthcare profession, so that all healthcare professionals think about the importance of employment for patients living with obesity and assist them in remaining or returning to work if this is a goal of their treatment.
- A greater focus on the causes of obesity should be provided in medical training, so that healthcare professionals have a full understanding about the complexity of the condition to tackle the common and stereotypical attitudes that they may have. This could help healthcare professionals to display more empathy towards their patients. This should include the development of educational resources to be built into educating future healthcare professionals.
- Alongside greater training about obesity as a medical condition, training and development also needs to focus on how healthcare professionals discuss obesity with their patients. Patients living with obesity should not be treated any differently on account of their weight, and so it is necessary that healthcare professionals know how to, and fully understand the importance of having a 'good' and 'meaningful' conversations with people living with obesity, and avoid making assumptions about their condition.
- Specialist nurses have been found to be really important in other chronic conditions for understanding specific patient needs and having conversations with patients about other aspect of their life (including work) that can have implications on their condition. It will be beneficial if there were more specialist nurses for obesity to help people living with obesity navigate the patient pathways and to provide individualised help and support when needed.

Recommendations for Healthcare Professionals

- Through asking permission from the patient, healthcare professions should identify whether job retention or returning to work is a goal of treating their obesity and associated health conditions, and whether work should be considered as a health outcome. It is important to identify whether work is bad for your patient, or whether aspects of the work environment increased their exposure to stigma and discrimination. If work is a health outcome, then use of the Fit Note will send a clear message to employers about what they can implement to help an employee living with obesity remain active at work. Healthcare professionals should therefore be asking themselves and their patients about whether helping them to stay or return to work is a positive goal of their treatment.
- Access to timely care and early intervention is important. Not only is every patient entitled to high quality care in a timely fashion, but there is also evidence suggesting that long periods away from work can have a negative impact on people living with obesity and related health conditions.

Early action, in partnership with the patient's goals can help to achieve the balance between health and employment.

- Patient treatment pathways should be co-designed between the patient and the healthcare professional to select appropriate levels of help and support.
- Healthcare professionals need to be aware of the weight management services that are available in their locality, so they know what support can be provided to their patients living with obesity. If a less fractured service is developed, then it will be easier for GPs in particular to refer people living with obesity to appropriate support.
- How conversations about obesity are framed is important and healthcare professionals should avoid catastrophising. There should be a focus on an individual's capacity rather incapacity.
- Adopt a zero-tolerance approach to stigma and discrimination towards people living with obesity. All patients should be treated with respect and dignity when receiving clinical advice and care. Healthcare professionals need to be aware of how their actions, behaviours and bias about people living with obesity can have an impact on their clinical care, and ultimately patient outcomes. Policies around appropriate and respectful language should be developed, including the use of people first language.
- Healthcare professionals need to avoid making assumptions about people living with obesity. With improved education and training, this could help healthcare professionals to move beyond the 'eat less, do more' narrative and develop a greater understanding of the underlying causes of a person's obesity. It is therefore important that healthcare professionals seek permission and take time to understand an individual's weight history, to fully understand the range of factors that may have contributed towards their condition.
- Occupational health and vocational rehabilitation specialists should work closely alongside both organisations and employees living with obesity to design and implement relevant workplace support programmes and workplace adjustments to help employees living and working with obesity safely return to, and/or remain in the workplace.