

Transcript for Prominence Weight Bias and Stigma – Unit 4: Competent, Patient-Centred Care

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Welcome to Unit 3 of OSE4ALL Obesity Stigma Education for all Healthcare Professionals.

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UNIT 4 - 4.1 Competent, patient-centred care: simple steps & tools that profoundly impact your patient

In Unit 4, we'll **bring CLINICAL frameworks** and practical tools together to enhance your practice, and outcomes for people living with obesity.

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UNIT 4 - 4.2 Learning outcomes

We'll look briefly at the tiered Model of Care for obesity, multimodal treatment strategies in line with best practice, how to apply 4Ms into assessment, and how to use communication tools to support health behaviour change. We'll also look at the clinical encounter when people with obesity attend for non-obesity related concerns, and how you can advocate for a stigma-free, equitable healthcare system.

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UNIT 4 - 4.3 Tiered model of care

All health professionals should be familiar with tiered or multilevel models of care for obesity, used in Ireland, similar to other OECD countries, and aligned with WHO guidance. This framework ensures that people receive the right level of support at the right time.

Primary prevention focuses on promoting healthy behaviours and

preventing weight gain through brief, non-judgmental conversations supported by wider population measures. Secondary prevention emphasises early identification and supportive, blame-free care for people with emerging obesity, building trust, addressing internalised bias, and screening for complications. Tertiary services provide specialist, multidisciplinary treatment for complex obesity, aiming to improve function, quality of life, and long-term health. Together, these tiers form an integrated, person-centred pathway that supports people across all stages of health.

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UNIT 4 - 4.4 Key message: treatment differs from prevention

Remember, obesity is a chronic, relapsing condition, and **treatment differs from primary prevention**.

The pillars of **treatment** include multidisciplinary support, including nutrition and activity, psychological or behavioural support, pharmacotherapy, and specialist multidisciplinary or surgical care. This multimodal approach reflects the biology of obesity and moves care away from blame.

Importantly, the WHO recommends that limited availability or access to treatment should not prevent health professionals from making appropriate referrals. Doing so helps ensure that services continue to develop in response to patient needs.

Now, let's look at some key tools you can use in your practice.

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UNIT 4 - 4.5 The 4Ms Framework

The 4Ms framework helps us understand the *drivers, complications, and context* of obesity.

We assess mental factors such as mood, stress, and trauma; mechanical issues such as pain, mobility, and sleep apnoea; metabolic indicators such as blood pressure, glucose, and endocrine function; and monetary or social determinants such as food access, cost, transport, and safety. This approach prevents assumptions and supports holistic, person-centred care.

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UNIT 4 - 4.6 When patients are attending with concerns other than obesity treatment/weight management

Patients frequently attend for issues unrelated to weight. Our role is to prioritise the presenting complaint, whether contraception, depression, joint pain, or respiratory symptoms. We must not redirect to weight unless there is a clear clinical reason, and even then, we always ask permission.

If a patient declines, we respect that choice without judgement.

This maintains trust, reduces stigma, and reinforces that patients are seen and valued as whole individuals.

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UNIT 4 - 4.7 Communication tools: asking permission, and the 5As

Best practice in obesity care is to use the **5As Approach**, which provide a clear and respectful structure for health-focused conversations.

1. Ask: Always begin by **asking permission** to discuss weight or related health concerns. This respects autonomy and reduces defensiveness. For example: *'Would it be alright if we talked about your weight in relation to your current symptoms?'*

2. Assess: Use the **4Ms** and the patient's priorities to understand health needs, contributors, what they've tried before, and any barriers they face. This step ensures **we** understand the drivers and impacts of weight on their health.

3. Advise: Provide clear, evidence-based options **personalised and relevant** to the patient's concerns and circumstance, not generic instructions. The aim is to give accurate, respectful information that aligns with their health goals.

4. Agree: Work together to establish **realistic, health-focused goals** that feel meaningful and achievable for the patient. These goals may relate to energy, mobility, blood pressure, sleep, or quality of life, rather than weight alone.

5. Assist: Support the patient with **ongoing follow-up**, referrals, problem-solving, and continuity of care. As with any chronic disease, obesity management requires sustained, consistent support over time.

And throughout the process, we can draw on **OARS** - open questions, affirmations, reflections, and summaries - to strengthen rapport and ensure the patient feels heard and understood.

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UNIT 4 - 4.8 Motivational interviewing

Motivational Interviewing (MI) complements the 5As.

It is a collaborative, person-centred style that helps patients explore ambivalence and strengthen their own intrinsic motivation for change.

We use open questions and reflective listening to help patients articulate their reasons for change - for example:

'What would improving your health allow you to do?' or

'What challenges make this difficult for you?'

MI avoids pressure, blame, or persuasion. Instead, it supports the patient in identifying what matters most to them and how they want to move towards it.

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UNIT 4 - 4.9 Creating a supportive clinical environment

A critical component of competent, patient-centred obesity care is ensuring that the clinical environment is physically and psychologically safe for people of all body sizes.

This includes accessible, accommodating equipment, sturdy wide seating, high-capacity scales placed privately, appropriately sized gowns and blood pressure cuffs, wide stable examination tables, and **step-stools** with handrails. Hallways, doors, and toilet facilities should allow safe, dignified movement for all patients.

Privacy and dignity are essential during weighing or examination. Patients should be asked for permission before weighing, offered the option not to see the number, and weighed without commentary or visible reactions.

The environment also includes the clinic's social atmosphere. All staff should use respectful, people-first language and avoid assumptions about behaviours. Waiting rooms should avoid stigmatising media and instead display inclusive, wellbeing-focused materials.

Creating this environment reduces barriers, protects dignity, and communicates clearly: **"You are safe, welcome, and respected in this space."**

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UNIT 4 - 4.10 Application to physiotherapy

Across all tiers of obesity care and across the lifespan, physiotherapists support function, physical capacity, and health-enhancing behaviours. Personalising care through practical frameworks such as the 4Ms, the 5As, and motivational interviewing supports thorough assessment, shared goal-setting, and appropriate progression of care. These approaches help physiotherapists identify key drivers of pain, limitation, and disengagement, problem-solve barriers to participation, and work towards meaningful and achievable outcomes focused on function, pain management, participation, and quality of life rather than weight.

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UNIT 4 - 4.11 Summary and takeaway message

This unit highlights that clinician knowledge and communication behaviours directly influence patient experience, and that applying these tools with consistency and empathy can improve trust, reduce stigma, and optimise clinical outcomes for people with obesity.

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UNIT 4 - 4.12 Overall conclusion and takeaway

As we conclude these four units, you can reflect on the knowledge and skills you have gained. I hope you have developed a deeper understanding of the biological and physiological science underpinning obesity, while also increasing your awareness of how your own biases could influence clinical judgement and patient experience. By integrating this scientific knowledge with evidence-based communication strategies and practical skills, you are better equipped to deliver empathetic, equitable, and person-centred care that improves interactions, reduces stigma, and enhances outcomes for the person living with obesity.

UNIT 4 Resources

- **Pillars of treatment** [1] [2, 3] [4]
- **Motivational Interviewing /OARS / 4Ms** [5, 6] [7, 8]
- **EASO Image Bank** <https://easo.org/media-portal/obesity-image-bank/> Educational links

References

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- [7] Barnes RD, Ivezaj V. A systematic review of motivational interviewing for weight loss among adults in primary care. *Obes Rev*. 2015;16:304-18.
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