

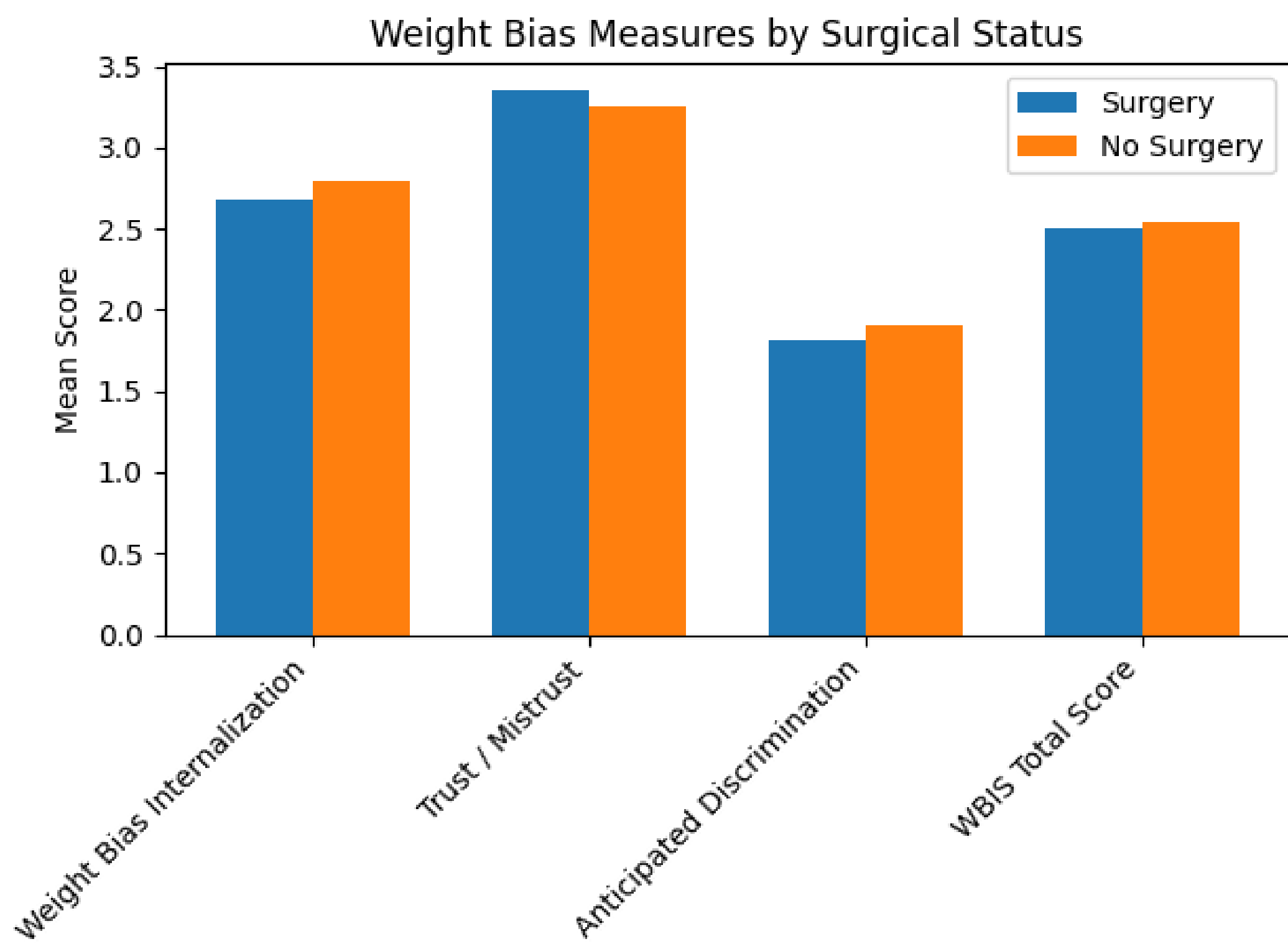
Introduction and Objective

- ❖ Obesity affects over 40% of U.S. adults and remains a major driver of morbidity and healthcare utilization.
- ❖ Weight stigma in healthcare is pervasive and has been associated with reduced trust, delayed care-seeking, and poorer clinical outcomes.
- ❖ Although bariatric surgery is the most effective long-term treatment for severe obesity, the role of perceived weight bias in influencing surgical decision-making remains unclear.
- ❖ We aim to examine the mechanisms by which perceived weight stigma influences bariatric treatment utilization and to inform strategies aimed at reducing bias, enhancing patient–provider communication, and advancing equity in obesity care.

Methods

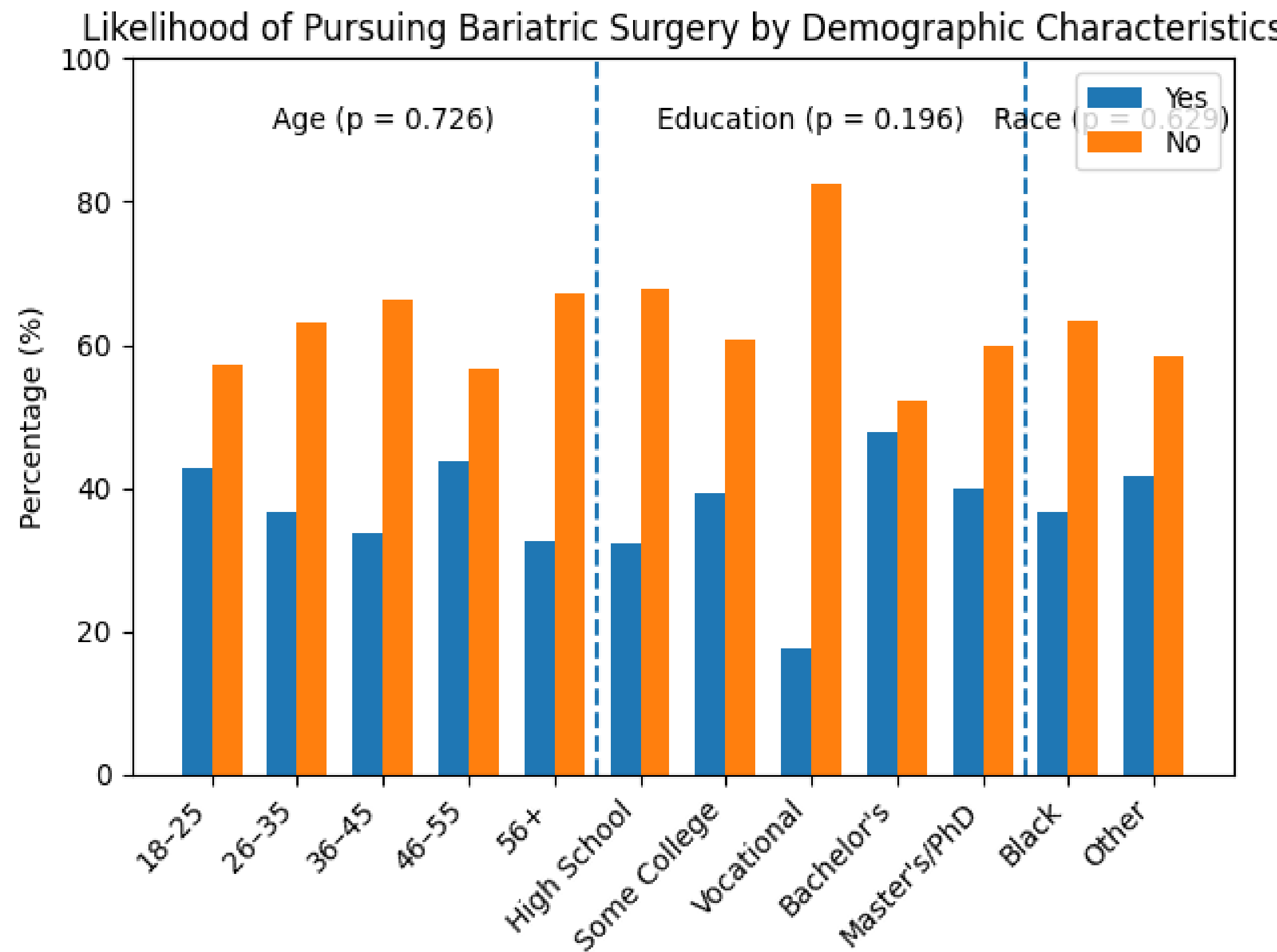
- ❖ Cross-sectional and retrospective study of adults with severe obesity evaluated in a bariatric surgery clinic between 2022 and 2024, reported in accordance with STROBE guidelines.
- ❖ Eligible participants were adults aged 18–100 years with BMI ≥35 kg/m² with an obesity-related comorbidity or BMI ≥40 kg/m² undergoing consultation for bariatric surgery or medical weight management.
- ❖ Patients with prior bariatric surgery or deemed not surgical candidates were excluded.
- ❖ Surgical status was determined retrospectively through electronic medical record review.
- ❖ Surveys assessing perceived weight bias were administered in person, by telephone, or via secure REDCap to minimize access-related exclusion bias.
- ❖ Validated instruments included the Weight Bias Internalization Scale (WBIS-M), Trust vs. Mistrust in Healthcare Providers Scale, and the Anticipated Discrimination Scale (InDI-A); composite mean scores were calculated.
- ❖ Primary outcome was comparison of weight bias measures between patients who underwent bariatric surgery and those who did not; secondary outcomes included associations with demographics and postoperative BMI change.

Results



WBIS total scores also did not differ significantly between groups (2.50 ± 0.44 vs. 2.54 ± 0.48 ; $p = 0.415$).

- ❖ Statistical analyses included unpaired t-tests, chi-square tests, and one-way ANOVA; two-sided p-values <0.05 were considered statistically significant.
- ❖ The surgery and non-surgery groups were demographically comparable.
- ❖ Mean age: 44.2 ± 12.5 vs. 44.8 ± 12.3 years ($p = 0.743$)
- ❖ Mean BMI: 46.7 ± 7.9 vs. 46.5 ± 8.5 kg/m² ($p = 0.907$)
- ❖ Majority identified as Black (89.6% vs. 91.7%)
- ❖ No significant differences in education level



- ❖ 37.1% pursued bariatric surgery
- ❖ No significant association between perceived weight bias and surgery decision
- ❖ No demographic differences (age, education, race)
- ❖ Significant postoperative BMI reduction across all groups

Conclusions

- ❖ In this cohort of individuals with obesity, perceived weight bias, internalized stigma, anticipated discrimination, and trust in healthcare providers did not differ significantly between those who pursued bariatric surgery and those who did not
- ❖ Although weight bias was commonly reported, it did not independently determine surgical decision-making, suggesting that stigma alone may not serve as a decisive barrier to bariatric care.
- ❖ These findings highlight that treatment decisions are likely shaped by a complex interplay of psychological, social, and structural factors such as socioeconomic status, health literacy, insurance access, comorbid disease burden, and readiness for change.
- ❖ While weight bias may not prevent access to surgery, it may still influence patient-provider communication, engagement in care, and long-term postoperative outcomes, underscoring the importance of addressing implicit bias in healthcare settings.
- ❖ Overall, bariatric surgery decision-making appears multifactorial, and advancing equitable obesity care will require patient-centered approaches, systemic reforms, and continued efforts to reduce stigma within clinical environments.

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