Print Close

Texas hospital reportedly bars obese workers -- and it might be legal

By Joshua Rhett Miller

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Not everything should be bigger in Texas.

A Texas hospital has reportedly instituted a hiring policy barring potential employees who are obese -- and officials at the Equal Employment Opportunity Commission tell FoxNews.com that the practice is not explicitly discriminatory.

The policy, which was instituted last year at the Citizens Medical Center in Victoria, requires potential employees to have a body mass index of less than 35. That equates to roughly 210 pounds for someone who is 5 feet, 5 inches tall or 245 pounds for someone who is 5 feet, 10 inches, the Texas Tribune reports.

An employee's physique "should fit with a representational image or specific mental projection of the job of a health care professional," including an appearance "free from distraction" for hospital patients, according to the policy.

David Brown, the hospital's chief executive, did not return several messages seeking comment on the policy, but he told the Texas Tribune that the hospital's patients have "expectations" regarding personal appearance that cannot be ignored.

"We have the ability as an employer to characterize our process and to have a policy that says what's best for our business and for our patients," Brown said.

Justine Lisser, a senior attorney and adviser at the Equal Employment Opportunity Commission, said the Americans with Disabilities Act would prohibit discrimination against the morbidly obese since that can be a covered impairment.

"There are, however, people who may have a BMI that is higher than what the hospital required, but not so high as to constitute morbid obesity," Lisser wrote in an email to FoxNews.com. "Unfortunately, these people would not be covered by our laws prohibiting discrimination because they would not have a covered disability."

One of the hospital's justifications for its policy, Lisser wrote, is that its patients expect some sort of professional appearance that, presumably, does not include being overweight.

"Under any other one of our laws, customer preference is absolutely no justification for discrimination except in very limited and narrow circumstances," her email continued. "So, for example, as happened in one of our recent cases, a home health aide service may not refuse to send out African-American nurses aides in response to customer requests; however, if the aide were to be involved in intimate care of women, it would be permissible to restrict the position to women."

If the hospital's BMI preference only applied to one group and not another -- say to African-Americans and not Caucasians -- that would constitute illegal race discrimination. Likewise, if it were applied solely to women and not men, that would constitute illegal sex discrimination, Lisser said.

"While our laws may not cover people who are overweight but not morbidly obese, the entire thrust of EEOC's mission is to have people considered for employment based on their qualifications and experience -- not on irrelevant factors," Lisser's email concluded.

Michigan is the only state that bans weight discrimination, although six cities -- Birmingham, N.Y.; Santa Cruz, Calif.; Madison, Wis.; San Francisco; Washington, D.C.; and Urbana, Ill. -- have also enacted weight discrimination laws. Madison first enacted its laws banning discrimination based on weight or personal appearance on March 13, 1975.

Lance Lunford, a spokesman for the Texas Hospital Association, said hospitals have the right to utilize policies to ensure the best

business

"Hospitals have a right, as any business does, to employ measures that ensure the most effective and efficient outcomes for the business," Lunford wrote in an email to FoxNews.com.

Attorneys contacted by FoxNews.com were largely split on the issue.

Bobby Lee, a Dallas-based employment attorney, said a "good argument" can be made that the policy is discriminatory.

"I can't imagine [the policy] becoming widespread because they'd be setting themselves up for lawsuits," he said. "You can imagine: If you're an overweight person who can do the job, you can say this is wrong."

Stephen Key, an attorney with Dallas' Key Harrington Barnes, said Texas law contains no specific prohibition on weight discrimination. Employers cannot discriminate solely because of race, age or religion, he said.

"If an overweight person applied for a job and they were denied and they sued, they would very likely lose," Key told FoxNews.com. "In fact, the case might be dismissed summarily because it doesn't state a cause of action under Texas law."

Key continued: "However, if a morbidly obese was denied employment, I would expect they would have a successful case ... So we have this weird situation where you can discriminated against if you're fat, but not if you're morbidly obese."

Weighing In

Healthy at Any Size?

As the number of obese and overweight children grows, so does size bias.

BY **CAMILLE JACKSON** ILLUSTRATION BY **GEORGE BATES**

CELEBRITIES LIKE SINGER JENNIFER Hudson and actress Kirstie Alley parade their drastic weight loss in commercials and magazine articles. Popular TV shows like *The Biggest Loser* promote fast, extreme weight loss. And fat jokes cut across race, ethnicity and gender lines to provide easy laughs for comedians at the expense of the heavyset.

Society is more fatphobic than ever before, with subtle and overt messages all around us that not only is fat bad, but so are fat people. It's easy for overweight children to feel singled out and shamed about their body size, at home and at school. Experts say children can easily interpret even the well-intentioned "war on childhood obesity," meant to promote health, to mean a war on their bodies and on them.

"The number of obese kids has increased, so negativity has increased," says Reginald Washington, the chief medical officer at Rocky Mountain Hospital for Children and a leader in the fight against childhood obesity. "It is true that if you are obese you are discriminated against in schools and the workplace, and even in your home. Physical education teachers see them as lazy and are harder on them in class. Studies have shown this."

Size-based stigma stems in large part from the myth that being fat is a result of a lack of self-control and willpower, says Rebecca Puhl, a psychologist and coordinator at Yale's Rudd Center for Food Policy and Obesity. "There are prevailing public perceptions about the causes of obesity, like the widespread belief that obesity is simply an issue of laziness," Puhl says. "This perception drastically oversimplifies the complex causes—societal and biological—of obesity."

Bullies Leave Scars

Lamar Richardson (not his real name), 25, of Greenville, N.C., remembers being humiliated in his sixth-grade physical education class when the coach jokingly suggested he wear a training bra. Richardson can still hear the laughter of his classmates.

"It affected me for a very long time," says Richardson. "I was not comfortable with my body image. Even when I got to high school, after football practice I would go straight home and shower, rather than go to the locker room." He is now in a fitness program at a local gym but says he "still has the same issues."

Am I biased about size?

+ Do I think obesity shows a lack of willpower?
+ Do I think that everyone wants to be thin?
+ Are all the heroines in our class stories slender?
+ Would I be willing to cast a heavy student as the lead in the class play?

Megan Hansen, the founder of a healthy-lifestyle support group in North Carolina, also isolated herself in high school because of her weight: "When you're fat you walk with your head down," she says. "You go from class to class not wanting anybody to see you." Megan says she was careful not to stand next to cheerleaders, for fear of being compared with them.

Lavinia Rodriguez, a clinical psychologist in Land O' Lakes, Fla., who treats eating disorders and weight issues, says most of the size-discrimination stories she's heard have come from adult patients. "Younger kids don't want to talk about that," she says. "They don't bring it up. The things they talk about suggest [size bullying], but they don't state it overtly." Richardson agrees: "I didn't talk to anybody about it," he says. "As a guy you're taught not to really share your feelings like that. You just suck it up."

Rodriguez points out that girls are more likely to talk about their body-image issues and self-esteem than boys.

"Girls tend to remember name-calling and boys remember getting beat up," she says.

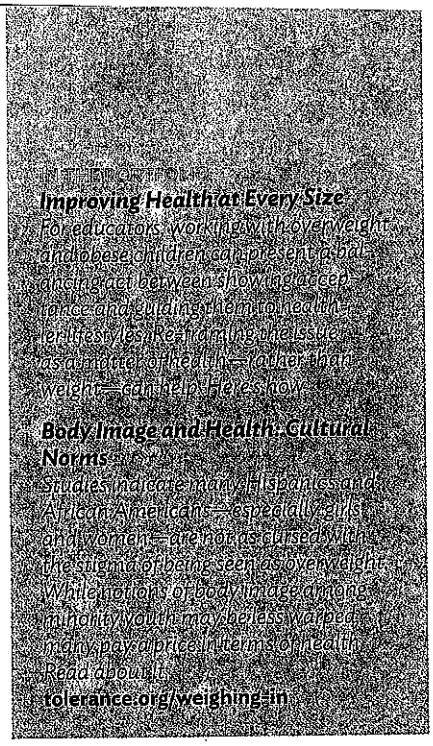
Bias in Schools

Unfortunately, educators often promote the negative stereotypes overweight students face. Studies show teachers tend to call on lean children over obese students. Some are less likely to give a favorable grade to overweight kids, and they generally perceive these children to be less successful. According to the Obesity Action Coalition, teachers often view overweight students as untidy and more emotional, among other problems. Obese students are also less likely to be accepted to college, despite having equivalent application rates and academic achievement.

State efforts regarding size bias in schools have thus far focused on reducing weight, not reducing prejudice. For instance, in 2003 Arkansas became the first state to record students' body mass index (BMI) and send the results home in a report card. However, federal agencies, including the Centers for Disease Control and Prevention, have not found enough evidence to recommend such programs as an effective strategy against childhood obesity.

The Arkansas program had no effect on obesity levels, according to a 2010 report by the state's Center for Health Improvement. And experts disparaged Arkansas's program coverage: "They didn't go the next step to give parents tools on how to design better meals and find afterschool activities," says Washington of the Rocky Mountain Hospital.

Yet Pennsylvania, New York, Massachusetts and other states soon followed with similar BMI-measuring programs. Georgia started a statewide school fitness program, the Georgia Student Health and Physical Education initiative, which seems to approach the issue in a more constructive way. In Georgia, kids are not labeled by their weight, says Therese McGuire of Georgia's Department of Education. Rather, "some kids will learn they are not in the healthy zone. It just means they need to make positive changes." Teachers will receive the students' data in aggregate form, she says, so that schools can customize their curriculum, for example by starting a running club.



Improving Health at Every Size

For educators, working with overweight and obese children can present a balancing act between showing acceptance and guiding them toward healthier lifestyles. Reframing the issue as a matter of health—rather than weight—can help. Here's how.

Body Image and Health: Cultural Norms

Studies indicate many Hispanics and African Americans—especially girls and women—are not as cursed with the stigma of being seen as overweight. While notions of body image among minority youth may actually warped, many pay a price in terms of health.

Read about it:

tolerance.org/weighing-in

Lobbying for Protection

Children should be legally protected from size-based teasing and harassment in school, says the National Association to Advance Fat Acceptance (NAAFA). The organization has called for changes in the proposed Safe Schools Improvement Act to add weight, height and physical appearance as protected categories, alongside race, religion and sexual orientation.

At a news conference last August in Washington, D.C., Peggy Howell, the organization's public relations director, unveiled NAAFA's online child advocacy toolkit, a 50-page booklet for parents and educators about size diversity.

"Discrimination continues to increase against people of all ages," Howell told a room full of reporters. One in six children are bullied, she said, and of those, 85 percent are bullied for their size or physical appearance. And Howell argues that programs such as first lady Michelle Obama's "Let's Move!" campaign, which began in February 2010, do not help matters. NAAFA contends that the campaign, intended to "solve the problem of obesity within a generation," should focus on the overall health of children rather than on body size alone.

"Low body weight does not equal health, high body weight does not equal disease," Howell said.

Rocky Mountain Hospital's Washington disagrees. He points out that obese and overweight children are more likely to have high blood pressure, diabetes, bone issues and other substantial problems. And obesity-related health problems cost states billions of dollars each year. However, Washington does agree with NAAFA that size discrimination is increasing, and says that it is up to adults to be self-reflective about their personal prejudice against overweight people.

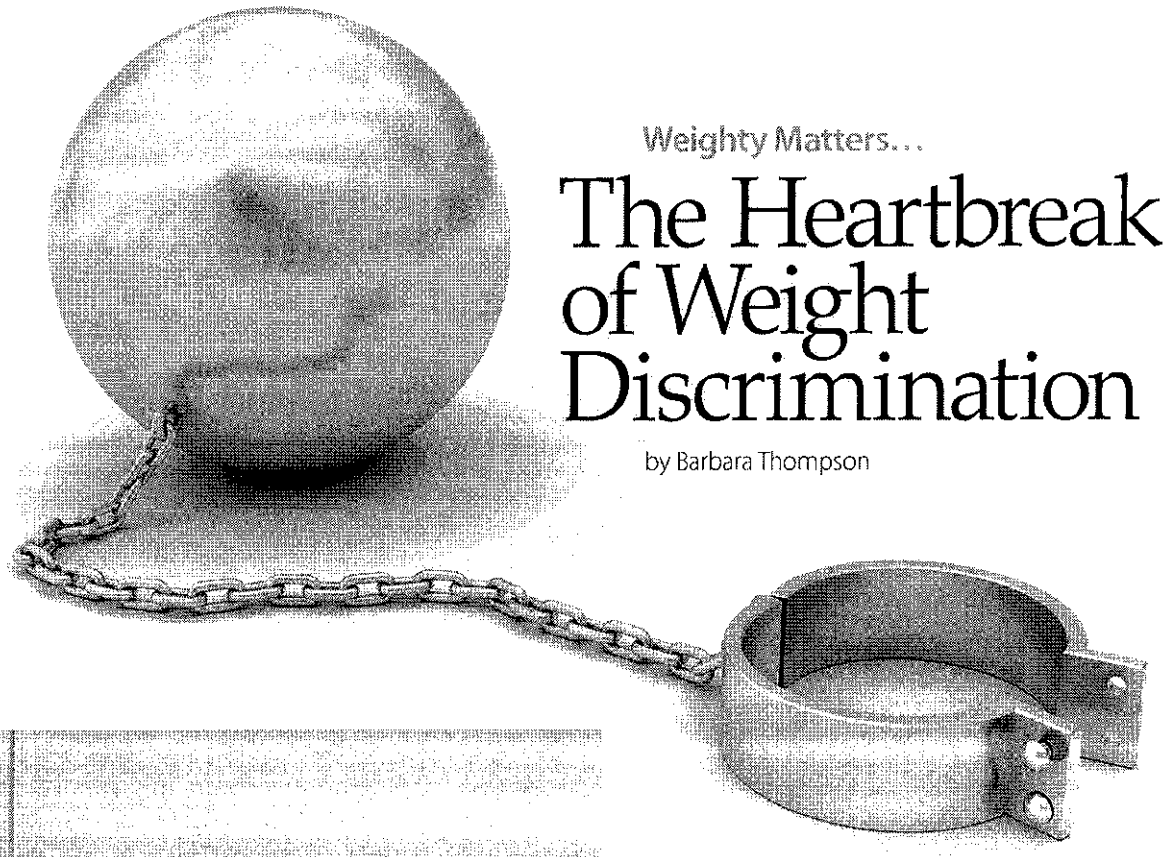
"Teachers have to look within themselves to ask, 'Am I a part of this problem?,'" he says.

What Schools Can Do

Schools can avoid perpetuating size-based stigma by de-emphasizing weight and BMI numbers and focusing on overall health for all children. Psychologist Rodriguez says attention needs to be paid to behaviors, not to numbers.

"Don't focus on one child as the one who has to do something different," she said. "It should be a family or school project. Parents are so focused on size, the weight, the number, they look at the symptom and just want to make the child lose weight."

Rebecca Puhl at Yale's Rudd Center says that teachers must be more aware of their own attitudes toward overweight and obese children. Those attitudes affect the overweight children directly and can indirectly promote bullying by other students. "Essentially, weight bias is rarely challenged, and often ignored," she says. "As a result many youth who are struggling with their weight are vulnerable." ◆



Weighty Matters...

The Heartbreak of Weight Discrimination

by Barbara Thompson

I was speaking in New Brunswick, New Jersey, in August 2002. It was just before my daughter was to go back to school, so I thought it might be nice to take her with me so that she could see what I did. We stayed at the Hyatt in New Brunswick and breakfast came with the room. We went down to eat late and when we got there, there was only one other table occupied. Four men were sitting at the other table talking and it was impossible not to overhear their conversation. As my daughter and I were eating, they started talking about how awful it is to sit on a plane beside big, smelly, fat people. They laughed and kept going on with this discussion. This was after I had my surgery, so obviously they felt comfortable speaking their minds because who would be offended?

At the time, my daughter was 15 years old. She was at the age when she believed that the world revolved around her and everything related back to her. I sat at my table listening to them and was getting angrier by the minute. I knew if I said anything my daughter would be embarrassed. I clutched the table trying to control myself as my daughter looked at me and said under her breath, "Mom, don't do it." My dilemma was, do I speak up and chance ruining this mother-daughter bonding trip or do I speak my mind?

They stood up to leave and I started to relax. They were leaving and I could just let it go. As luck would have it, they chose the exit route that took them right beside our table. They neared us and I was about to hyperventilate. They were alongside us and I was struggling for control. They were starting to walk away and I yelled, "Just a minute. I want you to know that a year ago I would have been one of those big, fat, smelly people sitting next to you on the airplane." I went on. I don't even remember what else I said, but they apologized and slunk off. I looked at my daughter and yes she was mortified, but she was also proud that her mother stuck up for what she believed in.

How is it that there is so much disdain for someone just because of their size? The obese are such easy targets when it comes to jokes, critical remarks, and definite discrimination when it comes to employment, treatment by healthcare professionals and in social situations.

"Discrimination against the obese may have its roots in the seven deadly sins which include gluttony and sloth,"

commented Dr. Christine Ferguson, Executive Director of the STOP Obesity Alliance, and Research Professor at George Washington University. "Perhaps it also has to do with fear," said Dr. Ferguson. "Because we all struggle with our weight, people have a fear that they will also become morbidly obese and they react with derision."

Children carry the same prejudices as adults. "Kids are cruel." We have heard it so many times that we believe it. Kids will blurt out, "Why are you so fat?" without a thought. Or, they will unmercifully tease and bully an obese child. But, kids aren't cruel. Kids just haven't yet learned to disguise their disgust and their prejudices. Their behavior is learned behavior. They express what their parents try to hide and what they have learned by example from their parents.

> In the 1970s, a well-known study was conducted asking children to select from a diverse group of children who they would like to have as their friend. At that time, a child in a wheelchair ranked last and second to the last was an obese child. The study was repeated in the 1990s and the obese child ranked last.

"Children as early as the age of three express prejudices," says Dr. Rebecca Puhl, Director of Research and Weight Stigma Initiatives at the Rudd Center, Yale University. "Schools have anti-bullying programs in place, but they don't include considerations for weight, and the bias and stigma that go along with feelings toward the obese. Schools also need to focus more on the health of all children, not just a number on a scale," added Dr. Puhl.

> Throughout our lives, the prejudice continues and it is worse for women than men. An employment discrimination study that was conducted by the University of Michigan looked at the net worth of 7,000 men and women in their fifties and sixties. The study found that moderately to severely obese women had a 40% net worth lower than their normal weighted counterparts. The same did not hold true for men.

There is still the perception that the obese chose to be the way they are. People look at race, gender, intelligence or handicap as acts of God. However, obesity is seen as a failure of a personal responsibility. This failure is misunderstood, even though the overweight and obese comprise the majority of the population, and just about everyone else has struggles to some degree with their weight.

Weight discrimination is all around us, each and every day. "The chronic condition of obesity carries with it one of the last forms of socially acceptable discrimination. Each and every day the negative stigma of obesity is perpetuated in media, film, television, print, online and many other areas," says Joe Nadglowski, CEO and President of the Obesity Action Coalition. "We, as a society, must put forth effort to eliminate obesity stigma and discrimination from our culture. Obesity is a multi-faceted condition; therefore, requiring a multi-faceted approach to addressing it. With that in mind, we must respect those affected by obesity, advocate for access to safe and effective care and educate the public on the physical, emotional and social effects of obesity."

What can we do to combat this culture of intolerance against the obese?

Here are some things to consider:

1. Examine your own prejudices. Do you ever look at the obese with disdain, especially now that you may have conquered your own weight problems?
2. Never be tolerant of others making negative comments about someone else's weight. None of us would choose to live life as an obese person.
3. Take active steps that will make you healthier. Realize that the goal of all of us should be a healthy lifestyle and not a number on the scale.
4. Do all you can to ensure that treatment for obesity, in whatever is the appropriate form, is included in the health care reform that the Obama administration is moving forward on. Write to your Senators and Congressmen and make sure they understand this needs to be a priority.

about barbara...
Barbara Thompson speaks professionally on weight loss surgery and obesity sensitivity. Information on her speaking can be found at www.BarbaraThompson.net. She is the author of Weight Loss Surgery: Finding the Thin Person Hiding Inside You and co-author of Weight Loss Surgery for Dummies which can be found at her web site www.WLScenter.com. She also offers a program for patients who are regaining weight. For more information, visit www.BackOnTrackWithBarbara.com.

Even today, as I begin to tell you of my previous work place discrimination, my heart sinks. By the age of eight, I knew I wanted to be a medical assistant, caring for patients. I was able to get a job in a doctor's office, not as a medical assistant since there were no vacancies, but as a receptionist. I felt that by being a receptionist, I had my foot in the door.

But, as time passed, so did the opportunities to "go to the back hall" as a medical assistant. With every opening, I would ask about the position only to be told that I was so good where I was that they needed me to stay there for now and to have patience. I had patience, five years of patience, and 12 openings came and went. I got up enough courage to lay it on the table and demand an answer as to why I was not being given the opportunity.

I worked there when I had my weight loss surgery in 2002. The looks of disgust and the whispers, how could I have that kind of surgery, "it's the cheaters way out." No support while I was post-op. My surgery was open RNY but because I couldn't afford to be off six weeks, I went back in the third week. And, even then, I was treated like I had a disease. No one helped me. I wore that big elastic belt around my torso and I know I looked like I was run over by a truck, but you would think if I dropped something or had to go get something, there would be someone that would help me, but no, nothing but stares and whispers. So, needless to say, when I did lose 89 pounds in the first year, only to start regaining 30 pounds the next year, the looks and whispers just got worse.

I remember to this day the office manager taking a deep breath and explaining that one of the doctors felt, due to my 230 pounds of weight and 61 inches of size, I would not be able to keep up with the speed needed for the doctors to stay on their scheduled time. And with my size, I would not be able to move around the exam table without disturbing the patient or doctor while the examination was going on. I ran out crying until there were no tears left in me. It was the most embarrassing thing I had ever encountered in my life. I put on another 30 pounds in the next couple months, eating every time I recalled the incident.

I finally got myself back together enough to look elsewhere for employment. I am now a medical assistant in a pediatric office. I have never been happier with a job than where I am today. The children look at me with eyes of joy when they see that "Nurse Pokadot" is here to take care of them and give them the magic shots that don't hurt. Today, yes, it still hurts thinking about not being able to prove myself to the other office, but then I would not be putting smiles on these kids' faces or bandages on their boo-boo's. So in a way, I should thank the arrogant orthopedic doctors for letting me find my true calling, working with the children.

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Section: HEALTH CARE ISSUE

Big Trouble

Medicine's deadly bias against the obese

On a Wednesday afternoon in June, a man I'll call David asked his sister to drive him to the emergency room at Boston's Brigham and Women's Hospital. Earlier in the week, he had visited another Boston emergency room after spraining his ankle. But, when the doctors there x-rayed the ankle and found no fracture, they sent him home. Now, a few days later, David's ankle was still hurting him--so much that he could barely get out of bed. Even more worrisome, when David did manage to walk around, he quickly became short of breath. That seemed strange for someone who was only 27 years old, so he wanted to get himself checked out.

Not long after he arrived at the Brigham and Women's ER, a nurse took David's vital signs. His temperature, pulse, and blood pressure were all normal. But his oxygen saturation level was low. That, combined with the recent ankle injury that had left him virtually bedridden, led the ER doctors to surmise that his shortness of breath was probably the result of a blood clot in his leg that had traveled to his lung--a pulmonary embolism. Normally, tests to confirm this diagnosis are fairly straightforward. But, with David, there was something that would make the tests--and his entire course of treatment, for that matter--extremely complicated: He weighed more than 550 pounds.

When the doctors sent David for a chest x-ray (to look at his lungs) and a leg ultrasound (to look for clots), the tremendous amount of fat and tissue in those areas made the images

practically impossible for the doctors to interpret--"like watching TV without cable or an antenna," as one radiologist put it. A helical CT scan of the vasculature in his lungs proved similarly difficult for them to read. David's high total blood volume--a function of his obesity--caused the contrast dye the CT technician had injected into him to become so diluted as to be almost invisible.

Nonetheless, the ER doctors still believed that the most likely diagnosis for David was a pulmonary embolism, and they decided to admit him to the hospital. (Full disclosure: My wife is a physician at Brigham and Women's, but she was not involved in David's care.) While David waited for an inpatient bed to open up, the ER nurses managed to insert an intravenous line in his wrist--no easy feat given the amount of fat between his skin and blood vessels--and the doctors gave him an anti-blood-clotting drug so that he might get a head start on getting better.

But, by the next afternoon, David's condition had taken a turn for the worse. Although his blood oxygen was better, his carbon dioxide level was dangerously high--and he had gone into respiratory failure. Finding him unconscious and unresponsive, a team of doctors and nurses worked quickly to insert an endotracheal tube in his windpipe, which they then attached to a ventilator to help him breathe. Intubated and unconscious, David was rushed to the hospital's intensive care unit, where a new team of doctors began to puzzle over his condition--and over how, if possible, they could make him better.

It is a long- and well-understood fact that obese people are more likely than non-obese people to suffer from any number of medical problems--from Type 2 diabetes to high blood pressure to heart attacks to colon cancer. But it is only recently that the medical world has begun to recognize that obese people are at greater risk for health problems that have no physiological connection to their weight. Medical researchers, for instance, have found that obese women are less likely to receive routine preventive care services, including pap smears, pelvic exams, and breast exams. And, while trauma is the fifth-leading cause of death in the United States, the mortality rate for severely obese individuals who have suffered a trauma is eight times greater than that of normal-weight people. Being fat, it seems, has never been more hazardous to a person's health.

What's more, an ever-growing number of Americans are facing that hazard. According to the most recent National Institutes of Health data, 32 percent of adults in the United States are obese--meaning they have a body mass index (BMI) greater than 30--as compared to 23 percent a mere decade ago. And much of that growth has occurred at the higher end of the scale. While the rate of obesity among Americans has gone up two-and-a-half times over the past 20 years, there has been a five-and-a-half-fold increase in the prevalence of Americans who have a BMI over 50. In 1986, it was estimated there were 175,000 Americans with a BMI over 50; today, medical experts estimate there are 1.6 million.

It's an increase that health professionals, not surprisingly, are noticing at their jobs. "When I started training in 1994, we would definitely see morbidly obese patients, but they were relatively uncommon," says David Feinbloom, a doctor who specializes in inpatient care at Boston's Beth Israel Deaconess Hospital. "Today, on my service, I encounter at least one morbidly obese person every month. It used to be one a year."

Which means that the medical world is just now beginning to grapple with the issues of how to treat people with obesity--and not just in terms of helping them lose weight. From creating equipment for larger patients to examining their own prejudices against fat people, medical professionals are starting to realize they must interrupt the vicious cycle in which the very thing necessitating that these patients receive quality health care--their obesity--all too often prevents them from getting it.

In October 2001, Marlene Schwartz traveled to Quebec City to attend the annual meeting of the North American Association for the Study of Obesity (NAASO). She was armed with a questionnaire. A Yale University psychologist, Schwartz studies weight bias; one of her favorite tools for measuring that bias is something called the Implicit Associations Test (IAT).

To simplify slightly, the IAT is designed to measure unconscious prejudice by timing people as they're asked to classify certain words. The IAT for weight bias, for instance, asks subjects to assign positive words (such as "motivated" and "smart") and negative words (such as "lazy" and "stupid") to the categories "thin people" and "fat people." If the test taker is quicker to match a positive word with "thin people" than with "fat people"--or, conversely, if the test taker is quicker to match a negative word with "fat people" than with "thin people"--he's demonstrating an implicit weight bias.

When Schwartz had given the IAT to students at Yale, she had discovered that, as a group, they exhibited significant weight bias. Now, as she handed out questionnaires to about 400 people in a Quebec City hotel ballroom, she wanted to know if the health professionals who specialized in obesity harbored similar anti-fat prejudices. The first indication that they did came before they'd even completed the IAT. "As people were taking the test," Schwartz recalls, "you could hear them making audible noises when they realized their own attitudes." And, as the test results eventually showed, those attitudes weren't kind toward fat people: As a group, those surveyed at NAASO's conference considered fat people lazier, more stupid, and more worthless than their thinner counterparts.

But, while Schwartz's findings were depressing, at least they were less troubling than similar studies of health professionals who don't specialize in obesity. A 2003 survey of 620 primary care physicians, for instance, found that at least 50 percent of them believed obese patients were awkward, ugly, and noncompliant. A 1989 sample of over 100 nurses, meanwhile, found that one in four of them were "repulsed" by caring for obese patients. Although you'd think

that medical professionals would be more in tune with the growing scientific consensus that obesity is a disease and not a failure of willpower, they obviously aren't.

And yet, in some ways, health professionals' negative attitudes toward the obese--while inexcusable--are understandable. One explanation is simple class bias. "When you think about the socio-demographic and economic backgrounds of many physicians, they often do not belong to groups that have the highest BMIs," says Christina Wee, an internist at Beth Israel Deaconess who researches obesity and health disparity issues. "So, in general, we physicians often have a different perspective--the people whom we know are often not obese, or at least not as obese as the patients we see in clinical practice."

Another explanation is that the medical profession often leans more toward the profane than the sacred, as doctors and nurses seek to leaven a stressful work environment with black humor--which frequently comes at the expense of those they're caring for. That some of that black humor would be internalized and converted into actual negative attitudes is, perhaps, inevitable.

Finally, health professionals are only human, in that they tend to get frustrated with people who cause them discomfort or harm--which, unfortunately, can often be the case with obese patients. According to a 2000 report from the Bureau of Labor Statistics, health care workers sustain 4.5 times more overexertion injuries than any other type of worker. And a 2004 industry survey found that 28 percent of respondents reported an increase in health care workforce injuries related to caring for obese patients.

Whatever its source, this medical bias against fat people doesn't go unnoticed by obese patients themselves--and it can have extremely deleterious effects. One recent survey of large women found that more than 60 percent of those who were severely obese had delayed or avoided getting a gynecological exam due to the "negative attitudes" of their medical providers. As Lynn McAfee, a 400-plus-pound Philadelphia-area woman who serves as the director of medical advocacy for the Council on Size and Weight Discrimination, elaborates: "You're laying there with your feet in stirrups, holding your own fat thighs apart and being lectured by somebody to lose weight. Or you're told, as I was by my gynecologist, 'So you're not sexually active.' And I said, 'Yeah, I am.' And she said later on, 'If you were sexually active,' and I interrupted her and said, 'I am sexually active!' And then it happened a third time. ... Gynecologists are generally not our friends."

The medical world is just now starting to come to terms with and combat its own negative attitudes toward the obese--with some sensitivity-training programs going so far as to have doctors and nurses wear fat suits. But eliminating prejudice is an awfully tall order. In the meantime, some medical professionals are just trying to work around it. At Massachusetts General Hospital's obesity treatment center, there is no formal sensitivity training for staff; but there's an expectation that patients will be treated with respect. And there are certain words

or terms--such as "morbidly obese"--that are verboten; "severe obesity" is the preferred term. "When you call somebody morbidly obese, you're really saying they're disgustingly disgusting, and that's not something we want to be doing," explains Lee Kaplan, the center's director. Even the MGH obesity treatment center's formal name--The Weight Center--is a nod toward destigmatization. The patients there seem to appreciate it. "One of the things we get commended most commonly about by patients is that we're actually nice to them," says Kaplan. "That should be the baseline."

According to his family, David, like many people with obesity, had long been reluctant to seek medical treatment for the simple reason that he was embarrassed by his size. So it was fortuitous, to say the least, that he had overcome that embarrassment and gone to the hospital on that June afternoon shortly before he stopped breathing. Had he been at home at the time, there's a good chance he wouldn't have survived the episode. But now, as he lay intubated and unconscious in the ICU, his survival was still very much in doubt.

The ICU doctors continued to treat David for a pulmonary embolism, but they also began to investigate other possible explanations for his condition--and they tried to answer the fundamental and pressing question: Why had he stopped breathing? It wasn't long before Rebecca Baron, the pulmonary critical care specialist who was now treating David, discovered an important clue. An extraordinary amount of fluid had accumulated in his lower extremities. "When I pushed my finger into his leg, there was an indentation that persisted and didn't go away," Baron recalls. "In most people, this is obvious. But, because he was so large, it wasn't readily apparent that all this extra body mass was fluid. I think everyone assumed, not unreasonably, that it was all soft tissue related to his obesity."

Baron immediately started David on a diuretic drug in order to get some of the fluid out of his body. (During his first nine days on the diuretic, he would be relieved of nearly 50 pounds of fluid.) Now the ICU team's attention turned to the question of what had caused David to retain all that fluid. Baron had a hunch. She ordered an echocardiogram--an ultrasound of the heart--for David, and she discovered what she suspected. The right side of David's heart--the part responsible for pumping blood to the lungs, where it picks up oxygen--was under extremely high pressure. One common explanation for that pressure is a huge pulmonary embolism. But a pulmonary embolism big enough to cause that kind of pressure would have almost certainly shown up on the earlier CT scan--even one as difficult to read as David's. Another cause for the pressure, however, made much more intuitive sense in David's case: chronic obstructive sleep apnea, which is a common problem for obese people. Over the years, sleep apnea caused him to suffer pulmonary hypertension--which, in turn, led to right heart failure. At last, David's doctors had arrived at a firm diagnosis.

This difficulty diagnosing the obese is hardly unique to David. In 2003, Raul Uppot, a radiology fellow at Massachusetts General Hospital, noticed something unusual: An increasing number of diagnostic images at the hospital were being deemed unreadable due

to the patient's "body habitus"--or build. Going through the past 15 years of MGH records, Uppot found that the number of images deemed unreadable due to body habitus had doubled. He then looked at census data to see if that trend correlated in any way with the prevalence of obesity in Massachusetts. Sure enough, it did. He presented his findings at the subsequent national conference of radiologists. It was the first time, Uppot boasts, that someone had conclusively proven that "obesity was having an effect on the ability to acquire diagnostic images."

Since then, Uppot has become something of an expert on the impact of obesity on radiology. The problems, he notes, aren't just limited to poor images. Oftentimes, patients are too obese to even attempt an image--since they either exceed the weight limit on the table or they're too wide to fit into the machine. Once, doctors could get around this problem by taking the admittedly embarrassing step of sending extremely obese patients to veterinary facilities where table limits on imaging machines went as high as 1,100 pounds. But even animal hospitals have begun buying radiological equipment with lower weight limits. Although some doctors now opt to send obese patients who can't fit in the standard MRI to what is called an Open MRI--which, as the name implies, is open so that it can fit anyone--they concede the images produced are of significantly lower quality. The result is that, in practical terms, the march of science is leaving obese patients behind. "When people have severe obesity and they get sick," says the Weight Center's Kaplan, "we're often forced to give them mid-twentieth-century medical care as opposed to twenty-first-century medical care."

Fortunately, the magic of capitalism is beginning to provide some relief. In recent years, diagnostic imaging equipment manufacturers have been racing to build machines that can accommodate bigger patients. In 2005, Siemens introduced an MRI machine called the Magnetom Espree, which has a 550-pound weight limit and a 70-centimeter opening. Since it was introduced, Siemens has delivered about 500 Magnetom Esprees--making it the company's best-selling MRI scanner in its class. Anne Sheehan, a Siemens marketing manager, can hardly conceal her glee about the Magnetom Espree when she says, "The U.S. market has totally embraced it because of our unfortunate situation with the obesity epidemic."

Indeed, the market for plus-sized medical equipment is booming--to the tune, according to some estimates, of as much as $3 billion per year. Companies with names like Big Boyz and Amplestuff now sell everything from extra-extra-large patient gowns and blood-pressure cuffs to 1,000-pound-weight-bearing hospital beds with built-in scales and double-wide wheelchairs. Even medical settings as prosaic as doctors' waiting rooms and hospital bathrooms are getting the super-size treatment: A 2002 article in the journal American Family Physician counseled doctors to equip their reception areas with "sturdy, armless chairs and high, firm sofas"; and many hospitals have begun replacing wall-mounted commodes with ones that sit on the floor.

Unfortunately, while there's lots of money for medical equipment geared toward the obese, there's not as much for medical research. Although the Department of Health and Human Services recently put out a major solicitation for research on improving health care for obese patients, the research dollars spent on obesity are still fairly paltry. Where the NIH budget contains more than $2,900 per patient per year spent on aids research and about $450 per patient per year for research on Parkinson's disease, research on obesity comprises only $6.56 per patient per year.

And the lack of research dollars has led to a lack of basic knowledge on everything from the proper drug dosing for obese patients (since some drugs are absorbed in fat and some aren't) to how to perform a proper physical exam on someone who's obese. Kaplan, who recently created an obesity medicine subspeciality at MGH in the hopes of luring doctors--and research money--to fill some of these knowledge gaps, points to one very elemental medical conundrum posed by some obese patients: the rectal exam. "For many patients, the rectal exam is useless, because our fingers aren't long enough," he says. "But there's no literature on the predictors of not being able to do a good rectal exam. It sounds almost like a late-night joke, but a lot of medicine is like a late-night joke. The problem is there's no information on this--and there needs to be."

As the doctors and nurses in the ICU worked to treat David for his right heart failure, they encountered difficulties with even the most routine aspects of his care. It was impossible for doctors to listen to his heart or lungs with their stethoscopes because there was so much soft tissue between their instruments and his organs. Their efforts to drain his body of fluid were occasionally interrupted when his pannus--the apron of fat and tissue hanging from his midsection--would fall onto his catheter and block it. Just turning David to clean him and treat a serious ulcer that had developed on his buttocks required five nurses and two doctors.

But the biggest impediment to David's recovery was his utter dependence on the ventilator. "We wanted to get his endotracheal tube out because you get inflammation, it's a good pathway for infection, it erodes soft tissue in the throat, and it means the patient has to remain on high doses of sedatives," says Lynn Matthews, another doctor who cared for David in the ICU. "Basically, people can't get better when they're intubated." But, every time the doctors tried to wean David from the ventilator by reducing the amount it assisted his breathing, his oxygen level would drop and he would go into respiratory distress. "Because of the excess fluid and his body mass, we had to use higher pressures on the ventilator to keep his lungs open and help his chest wall move so that he'd be able to breathe," Baron explains.

In an average-sized patient, a situation like this has a relatively straightforward solution: Keep the patient hooked up to a ventilator but remove the endotracheal tube from his mouth and insert a tube through an incision in the trachea. But surgeons were reluctant to perform a tracheotomy on David, deeming it too risky because of his labored breathing. The surgeons told the ICU doctors that, if they could get the ventilator pressure to a certain point, they'd do

the operation. So the ICU team continued to give David diuretics, and he continued to lose fluid. After several weeks, he had been drained of more than 150 pounds. But the pressure on his ventilator was still higher than the surgeons wanted it to be. Uncertain that the pressure would ever go lower, the ICU doctors prevailed upon the surgeons to do the operation anyway. In the middle of July, David was given a tracheotomy. Ten days later--and some 41 days after he first came to the Brigham and Women's emergency room--David was discharged from the hospital and sent to a rehabilitation facility.

Baron could only look back on David's case with wonder at how something so complex had actually been, in one way at least, so simple. "From the development of his underlying illness to his presentation to his care to his recovery, it all stems from the same problem," she says. "It's pretty amazing that it's all kind of linked together." As is the case for so many like him, David's obesity functioned as a medical conspiracy of sorts: First it made him sick; then it made it exceedingly difficult for him to be treated for that sickness.

As of this writing, David, who asked that his real name not be used in this article, is still at a rehab facility just outside of Boston. Although his tracheotomy tube has been removed and he is now breathing on his own, he is still a long way from being healthy. The ulcer on his buttocks that he developed during his long hospital stay has not fully healed. And, due to the fact that his leg muscles grew so weak while he was confined to a bed for 41 days, he is still in a wheelchair. More fundamentally, there's his obesity. His weight is now 370 pounds--nearly 200 pounds less than he weighed when he went to the ER back in June--but David is aiming to get it lower. His doctors have told him that he if he gets down to 350, they will evaluate him for weight-reduction surgery. "I can't go back to the same way I was," he says. "I want to lose more."

In the meantime, David is going to two hours of physical therapy each day, working on his leg and arm muscles. He's optimistic that he'll leave his wheelchair soon and then will be able to tackle his bigger medical challenges, but he's trying to be realistic, too. "I've got to crawl before I can walk," he says.

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By Jason Zengerle
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