

RESPECTFUL CARE OF OBESE PATIENTS IN CLINICAL PATHOLOGY LABORATORIES

PROBLEMS AND PROPOSALS

White Paper
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CONTENTS

FOREWORD.....	4
A message from CNAO.....	4
A message from Cerba HealthCare.....	6
OVERVIEW.....	7
INTRODUCTION: WHITE PAPER SCOPE AND OBJECTIVES.....	8
SPECIFIC CARE NEEDS OF OBESE PATIENTS.....	9
OBESTIY: A COMPLEX AND MULTI-FACTOR DISEASE.....	10
Defining obesity.....	10
A growing global epidemic.....	10
Obesity: increased risk factor for more than 18 serious illnesses.....	11
A complicated illness with poorly understood root causes.....	12
Obesity through another’s eyes: double victimization.....	12
Economic consequences of obesity.....	13
CLINICAL PATHOLOGY TESTS AND CHECK-UPS FOR OBESE PATIENTS.....	14
EXPERIENCE OF THE OBESE PATIENT AT THE LABORATORY.....	16
Waiting area.....	16
Check-in.....	17
Taking samples.....	17
Results.....	18
Summary table of identified irritants.....	19
RECOMMENDATIONS.....	20
Adapt.....	20
Train.....	22
Teach.....	24
BIBLIOGRAPHY.....	26
ACKNOWLEDGMENTS.....	27
CNAO.....	28
CERBA HEALTHCARE GROUP.....	29

A MESSAGE FROM CNAO

According to PMSI data from 2017, obesity is now a concern for almost the entire planet, including many emerging countries. According to the World Health Organization (WHO), 39% of adults in the world are overweight, and 13% are obese... This has led the WHO to recognize obesity and being overweight as the world's fifth leading cause of mortality.

Respect, paying attention, and listening are key for properly caring for Obese patients. Rates of excess weight, Obesity, and morbid Obesity have not stopped rising over the last few years. Today, half the population in France is overweight or obese, a total of 33 million people. What most people don't know, or don't fully understand, is that these extra kilos can contribute to 18 other illnesses. These include hypertension, breast cancer, liver cancer, colorectal cancer, ..., sleep apnoea, masculine and feminine infertility, diabetes, atrial fibrillation, etc. However, people with weight problems don't feel ill initially, or like their chronic metabolic function is suffering. Nevertheless, the WHO (World Health Organization) recognised obesity as a chronic illness in 1997, defining it as "excess weight and obesity are the abnormal or excessive accumulation of body fat, which may have negative health effects". Preventing obesity is a public health issue across the developed world. Because it can lead to so many other illnesses, obesity is today considered metaphorically to be a global pandemic, even though it is not an infectious illness. Still, despite many significant and varied commitments at the national level, France has still not recognized obesity as an illness. How can the general public and healthcare providers tackle this worldwide scourge if we're not all on the same page and fully recognizing the danger at hand?

That is why we (Cerba HealthCare and CNAO) decided to come together to create this white paper for anyone to read. Our primary goal is to provide better care for patients, support them a little more and a little better, and help them receive more effective medical treatment by providing specific adapted care. We hope to make moments like medical examinations into moments that are human, humble, rich with dialogue and an exchange of information between healthcare providers and patients. After all, happier patients mean happier providers. We, the patients, need you. We need strategies for living better with small day-to-day issues or we may need support for more serious illnesses. We, obese people, have many fears. Everyone has always told us that it must be our fault that we are obese (that may be partially true, but not entirely, we don't all have the same metabolism...). However, my fear is that when I go in for a medical examination, the chair won't be big or sturdy enough, or that the tourniquet will be too small. Will the injection go in on the first try? Will they be able to find a vein? Or will my vein roll again? I'm scared. I'm scared of being sick... I don't want to go. I won't go to the doctor's anymore! Anyway, it's all my fault...

We need help!

Proper care involves an entire array of behaviours, respectful attitudes, trying to find a suitable location, and high standards of professionalism. Everyone deserves to have their individual liberty respected, their physical and psychological well-being protected, the rhythm of their life, their desires, their tastes, their autonomy respected:

- I provide suitable care. I check that the staff has the equipment they need.
- I adapt to the patient's communication needs.
- To communicate and facilitate dialogue, I position myself at the person's physical level. I use simple words.
- I speak politely, avoiding too much familiarity or crude words and phrases.
- I use a tone that is respectful and warm, not infantilizing, degrading, aggressive, or sarcastic.
- I don't make any judgements.
- I pay attention to psychological trauma: harassment, rudeness, extortion, humiliation, threats, intimidation, shaming, infantilization, punishment, etc.

For everything that you already do for us, and all that you will continue to do: I want to say thank you, THANK YOU VERY MUCH!

A MESSAGE FROM CERBA HEALTHCARE

Cerba HealthCare believes in a human vision of clinical pathology.

Providing patients with optimal care, not only in terms of their health, but also by taking their specific needs into account is absolutely essential. Every patient is different, but all should feel understood, regarded, and supported in the same way. That is why we are committed to adapting what we do to better suit the specific needs of each patient category.

This is even more important when it comes to patients who are normally stigmatised in their everyday lives. Obese patients, in particular, get looks every day from people whose heads are full of preconceived notions, even though their healthcare is particularly important, given their pathology. Obesity is an illness, but an illness that can be treated. It is easiest to treat when it is caught early, as part of an integrated care approach where the patient's observations and commitment are key success factors.

However, improper equipment and the welcome they receive too often sometimes make lab visits difficult for obese patients. That is why we thought it necessary to focus with kindness and humility on the needs and expectations of obese patients, as well as those of healthcare providers, in order to adapt our practices to better care for these patients.

In an open innovation approach, we partnered with CNAO (*Collectif National des Associations d'Obèses*, or National Collective of Associations of Obese People) to take a step back and think from every angle about the expectations, needs, and concerns of both patients and providers. This project was executed in our innovation laboratory (Cerba HealthCare InnovLab), an accelerator dedicated to the Cerba HealthCare Group's innovation projects. Rather than keeping the fruits of this labour to ourselves, we have decided to share this report with all who want it, since we believe that proper care for obese patients is a serious issue that clearly goes well beyond the case of clinical pathology laboratories.

It is our modest hope that this report may inspire other healthcare professionals and patient groups. Such is our ambition, which will soon go on to include other patient categories that we want to welcome with particular care during their visit to the laboratory.

OVERVIEW

15-20% of French people are obese. This population faces serious stigmatisation, and their continued healthcare and prevention efforts are particularly important, given to the comorbidities and pathologies associated with obesity. Obesity increases the likelihood of 18 serious illnesses, though most can be avoided with adapted care.

It is therefore essential that we account for the specific needs of obese patients to improve their time in the clinical pathology lab and provide them with kind and welcoming care. Beyond the technical aspects of taking samples and interpreting a patient's results, which might make any patient anxious, obese patients often feel injured by how others view them, especially when infrastructure is poorly suited or feels "separated". As part of our open innovation approach, we made several recommendations in three areas: adaptation, training, and teaching.

- Adapting the physical space, equipment, seats, medical hardware, but also flows, processes, and interactions between patients and laboratory staff.
- Training staff on the specific needs of obese patients, on understanding and sharing best practices, and also training on the patient journey, whether that be their medical history or life history.
- Teaching not only the staff, but also teaching patients to create a constructive dialogue so that everyone can feel comfortable and obese patients will become more aware, observant, and involved in their pathology.

Obesity is an illness, but an illness that can be treated!

INTRODUCTION: WHITE PAPER SCOPE AND OBJECTIVES

Obesity is a chronic illness associated with eighteen other pathologies that is a major public health issue. As obesity rates rise quickly, more and more patients entering the healthcare system are obese, so it is essential that we think about the best way to receive this population in clinical pathology laboratories and throughout their patient's journey. However, when we asked obese patients, they said that their reception and the care they received often left much to be desired. Obesity is a complex, diverse, multi-factor illness with considerable social connotations, leading providers to sometimes hold expectations that are difficult for them to even perceive. The same goes for the intake process, which some patients find ill-suited. It was this observation that led us to work on the theme of proper care for obese patients in clinical pathology laboratories, with just a few simple ideas:

- Every patient should be able to receive optimal care, no matter what that care looks like.
- To reach this goal, we needed to account for the specificities of each patients and adapt our practices so that they felt that they were being received kindly, humanly, and efficiently.
- This an essential condition to keep them in the healthcare system, with positive impacts on prevention, observation, and ultimately leading to better health.
- A mutual understanding of each side's needs, expectations, and limitations helps everyone, patients as much as healthcare professionals.
- The greatest enemy of proper care is often ignorance.

That is why Cerba HealthCare and CNAO wanted to work together to reflect on how we can change our practices to develop this idea of proper care for obese patients, for patients overall, and thereby for healthcare professionals. Starting with the reality on the ground, we tried to think up different possible improvements to test and implement. With all of the humility that is necessary when one is addressing a problem of this complexity, we tried to make our small contribution to improving care by thinking about our own practices and adapting them to make them more human and better suited to our patients' needs. That is our commitment.

SPECIFIC CARE NEEDS OF OBESE PATIENTS

According to the French National Authority for Health (*Haute Autorité de Santé*), “proper care is a comprehensive approach to caring for patients, and to welcoming the patient’s family to better respect their rights and freedoms, to listening to them and taking their needs into account, all while preventing mistreatment. Promoting proper care is a major issue in today’s healthcare system. It improves:

- Patients’ involvement in their own care, a central part of healthcare quality and security
- Work life quality, with a focus on the meaning of one’s work
- The development of health democracy.”¹

Beyond this general definition, the collaboration between obese patients and healthcare professionals produced several definitions of proper care in the clinical pathology laboratory setting. Other than the essential ideas of empathy and “taking care” that are built into the medical relationship, a strong emphasis on accounting for difference and individuality emerged. This means that for each patient to feel like they are receiving equal treatment, we need to adapt how we provide care to each individual, not suggesting the same services and products or employing the same behaviours for every patient, since then we would only reach the least common denominator. That means taking the initiative to seek active understanding, to analyse, and to take actions that are relevant for patients and for the situation on the ground. While we are starting with obese patients, this drive to seek equality by reflecting on difference and differentiation will extend to all other practices, benefiting all of our diverse patients, or more simply, benefiting all patients.

Proper care means welcoming others while respecting their differences, taking care of them without judgement, and building a relationship based on trust, dignity, and empathy.

Proper care is an active goal throughout a patient’s journey through the laboratory, driving the teams to care for all patients with respect and empathy, ensuring they receive care that takes their individual nature into account.

¹ Haute Autorité de Santé, 7 September 2015 (www.has-sante.fr/jcms/c_915130/fr/promotion-de-la-bienveillance)

OBESITY: A COMPLEX AND MULTI-FACTOR ISSUE

Defining obesity:

Obesity is defined as an excess of weight due to increased adipose tissue mass² whether that be because each adipose cell stores more within it and/or because of an increase in the number of adipose cells³. The Body Mass Index (BMI, the ratio between a person's weight in kg and their height in squared metres) is used to diagnose excess weight and obesity:

Classification	IMC	Risque de morbidité associée
Insuffisance pondérale	<18,50	Faible (mais risque accru d'autres problèmes cliniques)
Eventail normal	18,50–24,99	Moyen
Surpoids:	≥25,00	
Préobèse	25,00–29,99	Accru
Obèse, classe I	30,00–34,99	Modéré
Obèse, classe II	35,00–39,99	Important
Obèse, Classe III	≥40,00	Très important

BMI and obesity⁴

Calculation formula: $IMC = \frac{Poids (kg)}{(Taille (m))^2}$

Even though BMI does not take into account the relative proportions of body fat and lean body mass, an important factor, it is widely accepted as the primary tool for diagnosing being overweight or obese.

A growing global epidemic:

There are more than 1.9 billion people over 18 in the world who are overweight, including 650 million who are obese. That's 39% and 13% respectively of the global adult population who are affected by excess weight and obesity. These figures have more than tripled over the last forty years. There are also 41 million children under 5 who are overweight or obese⁵, so the problem may become more serious over the coming decades. In France, 17% of the adult population is obese, whilst amongst children, 16% of boys and 18% of girls are overweight.

² World Health Organisation Obesity: preventing and managing the global epidemic. Report of a WHO Consultation. Technical Report Series 2003; (894)

³ Source CNAO

⁴ *ibid*

⁵ *ibid*

These figures have remained stable over the last ten years⁶, but they are marked by striking social and geographic disparities, with the child of a labourer four times more likely to be obese than the child of an executive⁷.

Obesity: increased risk factor for more than 18 serious illnesses

Whether it be due to an excess of fatty tissue or to a chronic inflammatory condition related to an excess of abdominal adipose tissue, obesity increases the risk of several comorbidities and even death by creating a large number of complications and other illnesses^{8,9}:

- Cardiovascular and respiratory diseases
- Type 2 Diabetes
- Arthritis
- Steatohepatitis
- Cancer
- Change in renal function
- Endocrine issues
- Venous issues
- Digestive troubles
- Endocrine issues with low fertility
- Cardiac rhythm issues
- Osteoarthritis
- Dyslipidaemia
- Hypertension
- Gall bladder illnesses
- Severe pancreatitis
- Cataracts
- Dermatological illnesses
- Thrombosis
- Gout

JE NE SUIS PAS BÊTE, L'OBÉSITÉ EST UNE MALADIE ET NON UN CHOIX DE VIE !

L'OBÉSITÉ N'EST PAS UN CHOIX DE VIE ! C'est une maladie reconnue par l'OMS !

POIDS (kg) = IMC (kg/m²) × TAILLE² (m²)

CLASSIFICATION 1997⁶

Moins de 18,5
Normal : 18,5 – 24,9
Surpoids : 25,0 – 29,9
Obésité Modérée : 30,0 – 34,9
Obésité sévère : 35,0 – 39,9
Obésité massive : > 40

LES ASSOCIATIONS DE PATIENTS DU CNAO AINSI QUE LES GROUPES PLURIDISCIPLINAIRES SONT LÀ POUR VOUS ACCOMPAGNER

CONSULTEZ VOTRE MÉDECIN

5 FRUITS ET LÉGUMES : appliquez avec plaisir les recettes du PNNS, Ministère de la Santé⁸ www.mangerbouger.fr

Chirurgie bariatrique et traitement médical intensif (IMI) : l'opération de traitement la plus efficace pour contrôler le diabète de type 2 chez les patients souffrant d'obésité comparée au IMI seul⁹.

GRÂCE À MES ACTIONS JE DIMINUE MES RISQUES DE :

- Diabète
- Ten-tén, infarctus cardiaque
- Dépression
- Maladie des artères ou cœur
- Dyslipidémie (A-tropies des lipides ou sang)
- Hypertension artérielle
- Maladie de la vésicule biliaire
- Pancréatite sévère
- Apnée du sommeil
- Hypertension artérielle
- Alcoolisme, cirrhose chronique
- Cataracte
- Maladie dermatologique
- Maladie pulmonaire
- Cancer
- Phlébite
- Goutte
- Maladie hépatique

D'ICI 2030, LE NOMBRE DE PERSONNES EN SURPOIDS DEVRAIT ATTEINDRE 3,3 MILLIARDS DANS LE MONDE⁹.

Ref 1) Organisation Mondiale de la Santé (OMS), Obésité, voir chapitre 4 de l'Annuaire N° 311.
Ref 2) S. Berthoin, B. Gervais, revue scientifique de l'obésité, Presse Méd. 2015; 39: 913-920.
Ref 3) HAS, Surpoids et obésité (adulte) : prise en charge médicale de premier recours.
Recommandation pour la pratique clinique, Septembre 2011.
Ref 4) Programme National Nutrition-Santé (PNNS) 2011-2015. M'a débrouille tout seul (en plus) et toi, ça va !
Ref 5) S. Berthoin, B. Gervais, J. P. D. S. Les complications cardiovasculaires métaboliques associées au diabète.
3. Prise en charge. N Engl J Med 2013; 374: 641-51.

Les professionnels de santé, les associations de patients ainsi que votre entourage peuvent vous aider !

N'hésitez pas à en parler.

Plus d'information sur : www.cnao.fr |  |  MEDICAL DEVICES COMPANIES

⁶ <https://www.inserm.fr/information-en-sante/dossiers-information/obesite>

⁷ <https://solidarites-sante.gouv.fr/actualites/presse/communiqués-de-presse/article/lancement-du-4eme-programme-national-nutrition-sante-2019-2023>

⁸ Conséquences pathologiques de l'obésité, La Presse Médicale, Volume 39, No. 9 pages 913-920 (September 2010)

⁹ Haute Autorité de Santé, Surpoids et obésité de l'adulte : prise en charge médicale de premier recours, Recommandation de bonne pratique - 26 Dec. 2012

Obesity also increases surgical and obstetric risks. Still, most of these consequences are reversible, hence the importance of providing adapted care.

Risque relatif des problèmes de santé associés à l'obésité ^a		
Grandement accru (Risque relatif bien supérieur à 3)	Moderément accru (Risque relatif compris compris entre 2 et 3)	Légèrement accru (Risque relatif compris entre 1 et 2)
DNID	Cardiopathie coronarienne	Cancer (cancer du sein chez la femme ménopausée, cancer de l'endomètre, cancer du côlon)
Cholécystopathie	Hypertension	Anomalies des hormones de la reproduction
Dyslipidémie	Arthrose du genou	Polykystose ovarienne
Résistance à l'insuline	Hyperuricémie et goutte	Altération de la fécondité
Essoufflement		Douleurs lombaires dues à l'obésité
Apnée du sommeil		Risque accru de complications au cours de l'anesthésie
		Anomalies fœtales associées à l'obésité de la mère

^a Toutes les valeurs du risque relatif sont des approximations.

Source: World Health Organisation *Obesity: preventing and managing the global epidemic. Report of a WHO Consultation. Technical Report Series 2003; (894), page 48.*

A complicated illness with poorly understood root causes:

Obesity is a complicated, multi-factor illness whose root causes remain unknown. While an overly rich diet and sedentary lifestyle undoubtedly play a role in developing obesity, they are not the only factors that vary from individual to individual that contribute to this illness. There are also genetic factors that have been shown to play an important but very complicated role, and a child is two to eight times more likely to be obese if they have obese family members. The role of intestinal microbiota is being studied more and more, and seems to also be important. Finally, there are environmental and lifestyle factors that come into play, such as insufficient sleep, stress, and even pregnancy¹⁰.

Obesity through another's eyes: double victimization

Obesity is a visible illness that is associated with a certain number of prejudices. Obese people are often thought of as lazy, negligent, unmotivated, lacking self-discipline, and less competent¹¹. The prejudices against obese women specifically are even harsher¹². As a result, obese people often face discrimination, especially in terms of employment, with 25% of obese men and 34% of obese women saying they have faced employment discrimination

¹⁰ <https://www.inserm.fr/information-en-sante/dossiers-information/obesite>

¹¹ Puhl RM1, Heuer CA., The stigma of obesity: a review and update, *Obesity (Silver Spring)*. 2009 May;17(5):941-64

¹² Puhl RM, Andreyeva T, Brownell KD. Perceptions of weight discrimination: prevalence and comparison to race and gender discrimination in America. *Int J Obes (Lond)* 2008; 32: 992-1000.

because of their weight¹³. 38% of women and 52% of men also believe that it is acceptable to refuse to hire an applicant because of their weight¹⁴. A test done by the Discrimination Observatory in 2005 showed that an obese person was three times less likely to get an interview for a sales position, and even when applying for a telemarketing position, the obese person received 24% fewer responses¹⁵.

The patient experience can also make an obese person feel stigmatised, for example, if they can't have an MRI image taken because of their size. Some healthcare professionals even harbour these prejudices¹⁶, which, in addition to the stigmatisation that obese patients may feel, can lead them to avoid medical treatment, even when they need it. Depression is also more common among obese people, with the risk of depression increased by 18% among men and 23% among women for every 4.7 BMI points over 30¹⁷.

Economic consequences of obesity:

Due to the multiple health problems that it leads to, obesity also represents a heavy financial burden on society. According to a 2019 OECD report, by 2050, obesity will cost the 52 countries studied a total of 425 billion dollars annually¹⁸, mostly due to the cost of treating illnesses that are related to excess weight. The direct cost of obesity already makes of 5% of the health budget in France, 11% in Germany, and 14% in the United States. In 2012, the economic impact of obesity in France stood at €20 billion, 1% of total GDP¹⁹. 32% of obese people suffer from a long term condition, compared to 15% of the general population²⁰. Finally, being overweight or obese reduces life expectancy by 1.5 to 8 years, based on the degree of obesity²¹.

¹³ *Ibid*

¹⁴ 9th Rights Defence Barometer, International Labour Organisation (ILO) on "Perception of Employment Discrimination", 2016

¹⁵ Obèse : l'incroyable discriminé, Observatoire des Discriminations, Université Paris 1 – Panthéon Sorbonne, September 2005

¹⁶ Flint SW (2015), Obesity stigma: Prevalence and impact in healthcare. *British Journal of Obesity* 1: 14–18

¹⁷ Tyrrell et al., Using genetics to understand the causal influence of higher BMI on depression, *International Journal of Epidemiology*, 2019, 834-848

¹⁸ The Heavy Burden of Obesity: The Economics of Prevention, OECD, 10 October 2019

¹⁹ Daniel Caby, Lettre Trésor-Eco No. 179, Ministry of Economy and Finance, September 2016

²⁰ *Ibid*, 2012 figures

²¹ Gover et al., Years of life lost and healthy life-years lost from diabetes and cardiovascular disease in overweight and obese people: a modelling study, *Lancet Diabetes Endocrinology*, 2015

CLINICAL PATHOLOGY TESTS AND CHECK-UPS FOR OBESE PATIENTS

There are recommendations for biological monitoring for obese patients undergoing surgery. Both in that context and in general, the dialogue between clinicians and technicians is extremely important. They should discuss tests to explore possible origins for the obesity during the initial examination, identify any associated pathologies, monitor the evolution of identified comorbidities, and highlight any deficiencies that may result from unsuitable or yo-yo diets, which should lead us to be vigilant, since they are often not mentioned by the obese patient. This is especially important when working with obese pregnant women. Thus, the clinical pathologist should and must suggest further tests to the clinician that are suited to the patient's situation and/or the results of previous tests. We should also note, once again, how important dialogue is between clinicians and laboratory, especially in catching associated pathologies or deficiencies incidentally.

Intake examination:

- Fasting glucose
- Possible lipid abnormality
- Uric acid
- Gamma-GT
- Transaminases
- Complete Blood Count
- Ionogram
- Creatinine



Based on the clinical context, further tests may be ordered to investigate an endocrine origin: TSH, Cortisol, and Urinary free cortisol.

Preoperative assessment for bariatric surgery (HAS 2017, nutritional and vitamin panel):

- | | |
|---|---------------|
| - Albumin | - Calcium |
| - Complete Blood Count | - Vitamin D |
| - Ferritin | - Vitamin B1 |
| - Transferrin iron saturation coefficient | - Vitamin B9 |
| | - Vitamin B12 |

Based on the existence of any associated pathologies, other tests may be ordered to monitor their evolution, such as Glycated haemoglobin (HbA1c) for someone with a Type II Diabetes diagnosis.

Postoperative assessment for gastric bypass (HAS 2019, annual check-up)

- Blood glucose
- HbA1c if diabetes diagnosed
- Hepatic work-up
- Creatinine
- Vitamin D
- Vitamin B12
- Complete Blood Count
- Ferritin
- Calcium
- Ionised calcium
- Albumin
- PTH
- Magnesium
- Zinc



Postoperative assessment for biliopancreatic diversion (HAS 2019, to be carried out 1 month, 4 months, and 12 months after the surgery, then annually)

- | | |
|---|-------------------|
| - Complete Blood Count | - Albumin |
| - Ferritin | - Calcium |
| - Transferrin iron saturation coefficient | - Ionised calcium |
| - Hepatic check-up with alkaline phosphatases | - Vitamin D |
| - Creatinine | - Vitamin B12 |
| | - TP |

Obese pregnant women: Normal assessment for a pregnant woman, with special attention paid to deficiency risks that may arise from various diets (to be investigated during the medical consultation). These tests may include ferritin, B vitamins including folic acid, vitamin D, etc.

EXPERIENCE OF THE OBESE PATIENT AT THE LABORATORY

In most cases, patients visit the clinical pathology laboratory because their doctor has ordered tests done. Very often, these tests need to be done after fasting. A normal visit includes an initial waiting period, which should be as short as possible, followed by an administrative check-in, where the patient talks with a medical secretary who will verify their personal information, the list of tests to be done, their social security information, and any other insurance information. Next, the patient waits for a second time for the person who will take their samples to take them into the sampling room. After confirming their identity and asking the necessary questions for interpreting their results later, the sample is taken, often a blood draw. Next, the patient leaves the laboratory and receives their results from a mobile patient application, or comes back to the laboratory for them. If they do come back, they can consult with a clinical pathologist if they so choose, either face-to-face at the laboratory, or over the telephone by calling a dedicated service. Of course, if their results indicate some pathology, the clinical pathologist will notify the patient's general practitioner, who will call the patient back to discuss their treatment.

This process is perfectly controlled, subject to a specific quality policy that aims to provide the best medical care possible for all patients. From the point of view of the patient, however, there may be more of an emotional impact. Patients may display different levels of stress, impatience, or concern, and may require different levels of service from clinical pathology laboratories, which need to adapt the services they provide to patients' varying need levels. Like any other patient, obese patients will see this process through their own lives, through the lens of their own experience, their own assumptions and values, both as a person and as an obese person. What we need to do here is identify how obesity creates certain situations for some patients, and try to understand how they will see their patient experience differently. This will allow us to adapt our practices and see them as patients like any other.

Waiting area and check-in:

No one likes to wait. Clinical pathology laboratories, however, are busiest during a very short period in the morning, when patients come in before going to work. This means that people often have to wait, even if laboratories do their best to make wait times as short and pleasant as possible. For obese patients, this moment poses some particular difficulties. While most patients arrive at the laboratory worried about whether their results will be "normal" or not, the obese patient knows right away that they will not be "normal", that their blood glucose will be too high, their lipid test will place them in an elevated risk category for cardiovascular issues, etc. Even if they are more or less worried about the results of a specific test, they know that they will be reminded that they are not in good health, that they are too fat. They will therefore either exhibit denial or a feeling of helplessness in the face of their situation ("I know, but I don't know

what to do"²²). Their relationship with the laboratory is therefore different right from the beginning.

In the waiting room, obese patients know that they will be looked at, just as they get looks any time they go out in public. The difference here is that they often have to stand most of the time, even if there are chairs or a seating area. Most times, the seats that are available (especially those with armrests) aren't made for obese people. Besides getting looks, standing presents other problems, putting too much pressure on the joints (ankles, knees, hips), becoming painful if the person stands for too long.

"In the waiting room, you just go in the corner, smile at the other people, and try to take up as little space as possible"²³

Check-in:

During check-in, the patient normally stands across from a reception desk. The discomfort of standing, a particular problem for obese people, continues to be an issue here. Given their lived experience and their feelings of stigmatisation, obese patients are likely to see this process in a particular light. If the receptionist has a certain attitude, looks at them or asks a question a certain way, the obese patient may feel rejection, which as we said above, they often already feel from the general population. While some tests (thankfully very few today) require asking the patient their weight at check-in, this can also be seen as stigmatising, especially if other patients are within earshot. Once check-in is complete, the patient goes back to the waiting area, generally for a shorter period of time.



Taking samples:

When the person who will take the samples comes to get the patient, the problem of feeling the gaze or perceptions of other people arises once again. It is generally more difficult to take samples from obese patients than from non-obese patients, and the technician may see the situation as more technically demanding or where it will take longer to find a vein, which may increase wait times for other patients. If these concerns are evident in the technician's behaviour, the obese patient may feel stigmatised once again, or even feel rejected. In the examination room, the obese patient will need to sit in a chair with armrests that is not necessarily adapted for someone of their size. The

²² Quote from an obese patient

²³ Quote from an obese patient

patient may also worry about the chair’s ability to bear their weight (it is not rare anymore to welcome patients over 150 or 180 kg at the laboratory). If the procedure requires that the patient answer questions about their health, about the reasons their doctor ordered a specific test, or about their medical history, these topics may be difficult for an obese patient, who may become bothered. At this point, the technician places a tourniquet around the patient’s arm. Many patients have had experiences in the past where the tourniquet was too short for their arm, forcing the technician to leave the room to go find a longer one, something that is often perceived as a reminder of their obesity.

The process of drawing blood itself is very technical, and may be difficult in patients whose veins are hard to see or feel, which is often the case for obese patients. In this case, the technician needs to take their time, call in a colleague, or give up on inserting the needle if they don’t think they will succeed. This is a particularly stressful situation for the technician, who may let their stress show, something that will immediately be perceived by the obese patient, making the situation frustrating, or even uncomfortable for both.

Results:

Except for some very specific tests, whose results can only be reported by the prescribing doctor, patients can access their results using a website, a dedicated mobile app, or by visiting the laboratory in person. If their results indicate an urgent need for further treatment, the clinical pathologist should contact the prescribing doctor first. Obese patients therefore receive their results just like any other patient, and these results are compared to reference values for the general healthy population. Often, the patient will fall outside of these reference values for certain indicators due to their obesity, and will have to ask themselves if its “really serious or not”. To help them interpret their results, the patient can speak with a clinical pathologist at the laboratory, or over the phone outside of the laboratory’s normal open hours.



Summary table of identified irritants

Stage	Irritant
Before check-in	"Anyway, my results are never normal"
	"Everyone is looking at me"
	"I can't sit down"
	"My joints hurt"
Check-in	"I feel judged by the receptionist"
	"Seeing my prescription, he / she knows for sure why I'm here"
	"Everyone can hear what I am saying"
	"My joints hurt"
Before sampling	"Everyone is looking at me"
	"I can't sit down"
	"My joints hurt"
Sampling	"I feel judged by the technician"
	"I'll never fit in that chair"
	"I'm afraid the chair won't bear my weight"
	"All these questions are humiliating"
	"The tourniquet is too short, that's annoying"
	"He / she will never find a vein"
Results	"My results aren't normal"
	"The reference value just isn't me"
	"If I go in to hear more about my results, won't I be judged?"



RECOMMENDATIONS

This analysis of the experience of obese patients in the clinical pathology laboratory setting, along with information about friction points, mutual misunderstandings, or inefficient communication between the patient and healthcare professional have led us to the following observations:

- Adapting physical spaces, equipment, and processes to the needs of obese patients is important
- The human touch is essential, since that is what most significantly shapes the patient experience and how it is remembered
- It's not enough to want to do the right thing, we need to use verbal and non-verbal communication to create an empathetic bond between the patient and healthcare professional
- How information is delivered and shared is a major area for improvement within the patient-healthcare professional relationship
- The mutual understanding of what the other person is experiencing and feeling needs to be improved, because it is often not verbalised, leaving room for often erroneous misunderstandings

In short, the recommendations to come out of this work can be summed up in three words: Adapt, Train, Teach.

Adapt:

The entire patient experience should be adapted to all patients, including obese ones, in the most discreet and least stigmatising way possible. This means having seats in the waiting area that obese people can use, without just having a bigger seat that everyone will immediately think is the “chair for fat people”, creating stigmatisation. That kind of solution is worse than nothing. Having lots of different seating options will allow each person to find what makes them comfortable. For example, having several large chairs, armless chairs, chairs with just one armrest, high-seated chairs (also very useful for the elderly or those who have trouble getting up), or other ergonomic options would allow each person to find something comfortable for them, without singled out for their physical characteristics. The chairs should also be able to bear maximum weights that accommodate obese patients, and chairs should appear sturdy so that obese patients know they can sit on them without breaking them. Of course, the variable layouts of laboratories, and the restrictions put on certain locations may make this difficult to adopt. That is why staff need to be trained locally to figure out how to adapt this principle for the realities on the ground where they work (see the “Train” section).

During check-in, another simple solution for minimising standing time for obese patients might be to adapt the check-in counter for people with reduced mobility (lower and wider, accessible while sitting) by providing built-for-purpose chair. In laboratories with this kind of set-up, we observed that this counter is used

indiscriminately by people with reduced mobility, pregnant women, elderly people, as well as by any other patient who would rather sit during this part of the process. It is therefore totally not stigmatizing.



In the examination rooms as well, there are many simple steps that can be taken. For example, stocking each room with two tourniquets, one of standard length and a longer one. This is a low-cost solution that keeps everything they need to work with the patient sitting across from them right at the technician's fingertips. Besides making it easier for the technician, who doesn't have to get up to find another tourniquet, as well as for the patient, who no longer feels like a "problem patient"²⁴, this can also save time during the laboratory's busiest hours. The same goes for any other equipment used when taking a sample, including specula and medically assisted reproduction equipment, even if it may cost significantly more than tourniquets. The most important issue, however, remains the blood drawing chair, which is a particularly costly piece of hardware. More adapted chairs, ones that are larger and/or that have detachable armrests can be selected the next time the laboratory routinely replaces its equipment. Nevertheless, there are simple steps that can be taken, invisible to other patients, like directing obese patients to the largest examination room. This might mean having the receptionist always assign obese patients to the most experienced technicians and/or those working in the largest examination room. We should note that the same process could be used for other patient categories with more complicated sampling procedures, such as children, people with reduced vein integrity, pregnant women, or anyone the receptionist identifies as being in a state of elevated stress. Other options, like special procedures for obese patients, such as letting them cut to the front of the queue were considered, but ultimately dismissed because they were seen by both obese and

²⁴ Quote from a patient

non-obese patients as potentially discriminatory. Generally speaking, the entire patient experience should be adapted coherently and consistently. For example, the way the toilets are laid out is something to consider if the facilities are to be renovated.

Finally, as mentioned above, reading the test results is a moment that can be greatly improved for obese patients. Reading out the results and advising the patient about them are central parts of the clinical pathologist's role. That is why in any laboratory, patients can request a meeting with the clinical pathologist to have their tests interpreted and to get answers to any questions that they may have.

Train:

The medical relationship is above all a human relationship. This means that renovations and new procedures will have no effect if human relationships are not placed at the heart of the patient experience. Changing the culture of how we treat people starts with training and awareness raising. One of the goals of this White Paper, in fact, is to inform laboratory staff about the specific issues to consider when working with obese patients, thereby creating the conditions for change: how can I adapt my practices to make my obese patients more comfortable while also creating the conditions that will allow them to express themselves, letting us work on improving their experience together?

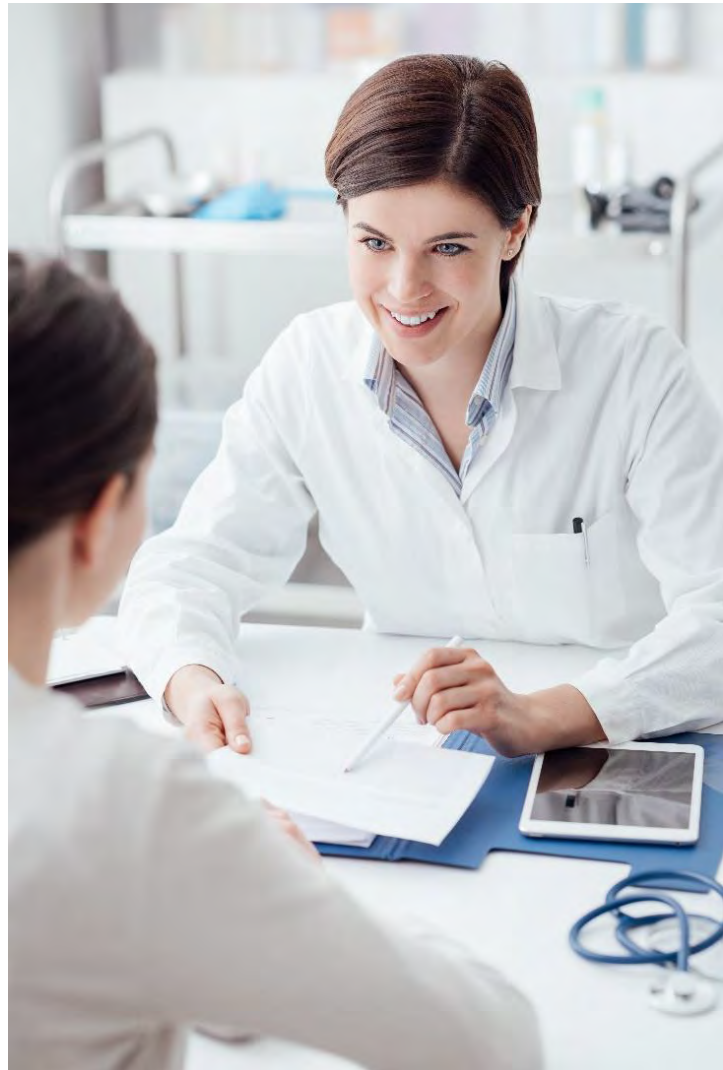
As we have seen, the way people think about obesity is often riddled with prejudices, and healthcare professionals are no exception to this rule. Prejudices are often rooted in our collective unconscious, leading us to adopt ineffective body language, even when our verbal communication is up to standard. That is why we have chosen not to provide a list of behaviours to adopt, but rather are identifying the tools, settings, and content that help to raise awareness and better train laboratory staff. Some possible options include sharing and exchange sessions that mix obese patients and caregivers, e-learning sessions on obesity and its specific issues in the laboratory context, as well as brainstorming sessions about how to improve existing practices. Structures like Corporate Universities or Innovation Labs, such as exist within the Cerba HealthCare Group can help to channel and accelerate these initiatives. At the same time, exchanges should be facilitated between conventional laboratory staff, and staff from laboratories that specialise in treating obese patients, including those undergoing bariatric surgery. This kind of peer training, which fosters a sense of Group belonging, is an effective tool because it promotes a general sharing of best practices and lets staff members know who they can go to if they have a question. Cerba HealthCare Group has a company social network, CerbaLink, that can also be used to this end, to create and run a dedicated community, for example. Outside the strict context of the clinical pathology laboratory, trainings for other actors involved in the patient experience should be considered to help further spread best practices for working with obese patients. One of the essential goals of this approach is promoting mutual understanding and allowing both obese patients and caregivers to share the issues they have faced without

judgement, in order to dispel any mutual distrust and foster communication. For example, obese patients often know where on their body it will be easiest to draw blood, and they are willing to share this information with the technician if they think they will listen.

Short theoretical trainings should also be provided for receptionists and technicians to help them instantly identify the purpose of a battery of tests based on what has been ordered. This is because some patients said they would feel better if the technician asked them to confirm that they were there for testing in preparation for bypass surgery, for example, rather than asking them why they had come in that day²⁵. This is a small detail, but it can help to instantly create a feeling of mutual understanding and trust, and it involves the kind of specific staff training that can also help them find more interest in their work. The same training could also be offered to receptionists to help stave off any possible misunderstandings.

For example, patients who lose a lot of weight after bypass-type surgery report feeling differently about their check-in process for their annual vitamin test before and after they lose the weight²⁶. When an obese person comes in for a vitamin test, it is usually related to surgery they have had, while for non-obese people, it is usually part of their general wellness, especially since some vitamins, which have to be taken as part of the surgery follow-up, still remain not reimbursed for the patient.

The advice given above applies to any member of staff to comes into contact with patients: receptionists, technicians, nurses, and clinical pathologists. Beyond any awareness raising and patient relations training, we also recommend, especially for clinical pathologists, to seek out better tools for interpreting obese patients' tests, with key points for managing their dialogue and relationship with obese patients better, helping them to get more out of the



²⁵ Interview with a obese patient

²⁶ Interview with a obese patient

interpretation of their test results. While the medical part of this interpretation, the core skills of the clinical pathologist, can hardly be improved upon, the work that went into creating this White Paper revealed several areas for improvement in terms of how the conversation is managed, as well as the need to adapt this interaction to the specific needs of obese patients.

“I just want to feel understood”²⁷

Teach:

Information is an essential part of improving the patient experience for obese patients in the clinical pathology laboratory setting. Teaching here means both internal and external training, for staff (as discussed above), obese patients, other patients, and all other stakeholders in this ecosystem. This means that laboratories can become a source of information that is highly useful to patients. For example, information about the 37 obesity specialist centres that exist around the country and about the different networks in place for treating obesity. Clinical pathologists might create local networks with other healthcare professionals interested in the same topic (doctors, nurses, midwives, physical therapists, nutritionists, etc.), helping to optimise the patient experience for obese patients from the bottom up. Laboratories can also act as essential sources of general and specific medical information about obesity and treating obesity. This information could be available as videos that are shown on screens in the waiting room, as paper pamphlets available to patients, or through poster campaigns. Besides providing information to obese patients, these actions also help to change how other patients think about obesity and about those suffering from it.



At the same time, information about health and test results, especially when a patient falls far outside of the reference values, can be communicated in concert with specialist doctors to help better inform patients and make them more

²⁷ Quote from a patient

observant of their own health without stigmatising them or making them feel even more guilty.



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CNAO

Founded in 2003, CNAO (*Collectif National des Associations d'Obèses*, or National Collective of Associations of Obese People), is a grouping of 50 patient associations from metropolitan and overseas France, accredited by the Ministry of Health.

The national headquarters in Paris focuses mostly on:

- communicating information to associations and the general public
- acting as a preferred dialogue partner for Oversight authorities
- preventing this pathology from growing more serious
- working in perfect harmony with various scientific associations (SOFFCO-MM, AFERO, etc.)

Its goal is to understand and support patients better, to help public authorities make better decisions to prevent the spread of obesity (Ministry of Health, Ministry of Education, Ministry of Youth and Sport, National Authority for Health, etc.) and to hold agribusiness companies to account on the ingredients they choose for their products and on the advertising efforts that surround them.

An active volunteer since 2000 and founder of CNAO, Anne Sophie Joly has served as an expert on 12 National Authority for Health best practices committees, with a focus on obesity and weight issues. She has also worked with the commission on patient information (all pathologies), served as a member of the presidential commission working group under Nicolas Sarkozy that produced Plan Obésité, worked on the Ministry of Health's "Obesity roadmap", sits on the board of PNNS, PO, DGS, DGOS, Santé Publique France, IGAS, and is an official reporter for the Ministry of Health general secretariat.

She is also a member of the "*Etats Généraux de l'Alimentation*" (Nutrition Assembly), convened by President Emmanuel Macron, a qualified member of the CNA (inter-ministerial group that includes 4 Ministries: Finance, Ecology, Agriculture and Food, and Health, created in January 2018 by decree), of the Health Commission of the Superior Council of Audiovisual, Lecturer at the Sorbonne for their certificate program on Obesity at the La Pitié Salpêtrière Hospital Centre, for the Paediatric Nutrition certificate program at the Trousseau Hospital Centre, and the Bariatric Surgery certificate programme at the Lille Regional University Hospital on Therapeutic Education for patients and doctors.

Member of EASO-ECPO since 2009, Anne-Sophie Joly received the "Ordre du Mérite" for her work in February 2016 from Patrick Kanner, the Minister of Sport and Associations.

CNAO is certified internationally by the CAF America "Quality Label".

CERBA HEALTHCARE GROUP

Cerba HealthCare is an international reference group in clinical pathology, with common values based on five synergistic and complementary activities:

- Specialised clinical pathology focused on Cerba in the Paris region
- Local clinical pathology, with a network of nearly 650 clinical pathology laboratories across France, Belgium, Luxembourg, and Italy, and in 13 African countries since the end of 2018
- Veterinary clinical pathology and genetics with two laboratories in the Paris and Lyon regions
- Central lab testing for clinical trials with a network of laboratories that spans continents (Europe, United States, South Africa, Australia, China)
- Central lab testing for IVD trials with a dedicated platform within Cerba

8,500 Collaborators

650 Laboratories

27 million Patients/year

A professional and medical project

The Cerba HealthCare Group's mission consists of a professional and medical project based on the multidisciplinary nature and synergy of its various entities' expertise. It offers healthcare professionals, private and public healthcare institutions, private and public clinical pathology laboratories, the pharmaceutical/in vitro diagnostics industry, and veterinarians a complete range of diagnostics tests and a chain of technical and medical skills and expertise necessary for prevention, screening, diagnosis and therapeutic follow-up. It is rooted in theranostics given that it contributes to the development of new therapeutic molecules in partnership with the pharmaceutical industry and is involved in adapting and monitoring patients' treatments. All Cerba HealthCare Group laboratories have COFRAC ISO EN 15189 standard accreditation. Efficient patient care is provided via logistical expertise (dedicated to the collection and transport of samples), the technical expertise of teams in charge of analytical platforms (dedicated to the conduct of clinical pathology tests), and the medical expertise of pathologists (dedicated to serving healthcare professionals). Its cross-border network allows it to offer equal access to all clinical pathology tests, including those that are most innovative, and to do so for the greatest possible number of people. The Cerba HealthCare Group has a panel of clinical pathology tests covering all medical specialities. Its Innovation and Development Department organises collaborative activities for the Group's multidisciplinary and research units, university hospital teams, biotechnology companies and start-ups with the goal of promoting the development of new biomarkers and services.

The Group is also a valuable contact for authorities and institutions involved in the public health and health monitoring fields. In total, the Group is almost 8,500 professionals who work every day with public and private healthcare professionals to ensure that patients have local access to high-quality innovative testing services near where they live.

- 50 years of clinical pathology expertise
- Headquarters located in the Paris Region
- + 650 laboratories
- Located across continents
- + 8,500 employees
- + 560 clinical pathologists
- + 27 million patients per year
- + 1,000 scientific publications

