Episode: *Author Interview: "Patient-Centered Approaches to Using BMI to Evaluate Gender-Affirming Surgery Eligibility"*

Guest: Whitney Riley Linsenmeyer, PhD, RD, LD
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[bright theme music]

TIM HOFF: Welcome to another episode of the Author Interview series from the *American Medical Association Journal of Ethics*. I'm your host, Tim Hoff. This series provides an alternative way to access the interesting and important work being done by Journal contributors each month. Joining me on this episode is Dr Whitney Riley Linsenmeyer, an assistant professor of nutrition at Saint Louis University in St Louis, Missouri, and a spokesperson for the Academy of Nutrition and Dietetics. She's here to discuss her article, coauthored with Dr Sarah Garwood, "*Patient-Centered Approaches to Using BMI to Evaluate Gender-Affirming Surgery Eligibility*," in the June 2023 issue of the Journal*, Patient-Centered Transgender Surgery Care*. Dr Linsenmeyer, thank you so much for being on the podcast. [music fades]

DR WHITNEY RILEY LINSENMEYER: Thank you for having me.

HOFF: So, what's the main ethics point that you and Dr Garwood are making in this article?

LINSENMEYER: The key ethics point is that this one singular number used to classify bodies, or BMI, is often used as a criteria for what is considered to be medically necessary and lifesaving surgery, and yet it's really not empirically based. So, in this article, we conducted a mapping review of the current research on BMI as a predictor of gender-affirming surgical outcomes. And in total, we retrieved 11 studies: five related to mastectomies, one on hysterectomies, one on metoidioplasties, three on vaginoplasties, and then one study that grouped all gender-affirming surgeries together. And in only one of these studies—and that was in a study on patients undergoing mastectomy—infection risk was higher with morbid and super obesity, or a BMI that exceeded 40 and 50, respectively. And among all those other studies BMI was not a predictor of adverse outcomes. And I think just on, you know, when we think about an individual patient, this is common. I have a patient right now who really wants to get bottom surgery but was turned away from the surgery center because of her BMI, but really then, with no support for how to lose weight in a healthy way or even just a broader conversation about her overall health. So, she's feeling pretty stuck right now.

HOFF: Yeah. Our episode next month of *Ethics Talk* will focus on exactly that, on BMI-based denials of care and of payment, which as you note, can place patients in some pretty difficult situations while they wait for the care that they need.

LINSENMEYER: Yes.

HOFF: Turning back to your article, however, what do you think is the most important thing for health professions students and trainees to take from this article?

LINSENMEYER: So, in this article, we propose what we describe as a patient-centered approach to using BMI in evaluating gender-affirming surgery eligibility. So, there's four points to

this. The first is to use reliable predictors of gender-affirming surgical outcomes rather than just a strict BMI cutoff, like a cut off of 40 or something like that. And I will say that good, accurate predictors of surgical outcomes for each type of procedure are still a growing body of research. And second is to consider BMI as just one data point in a patient's overall weight status since we know it's really just a ratio of weight and height. Other measures to consider can include body composition or body fat percentage versus lean body mass and also, body fat distribution. And then third is to discuss the patient's desires for their own body size with them. Students can resist the tendency to just assume that all patients desire a body size that's within that healthy BMI range. For example, I always think of I've worked with a trans man who really wanted a larger body size because all the men in his family had larger bodies. So, to him, it was really an expression of his masculinity. So, instead of just assuming, students can discuss the patient's desire for their body size with them. And then the fourth point here is that when a patient does desire to lose weight genuinely, to collaborate with the patient to identify supporting strategies. For example, instead of just saying, "Your BMI is too high and needs to get down to X or Y," we can refer patients to a support system of registered dietitians or a structured weight management program.

HOFF: And finally, if you could add a point to your article that you didn't have the time or space to fully explore, what would that be?

LINSENMEYER: Sure. One thing that I've heard from fellow clinicians is this possibility that patients are getting turned away from surgeries because their BMI, they're told to lose weight, and they wind up perpetuating really unhealthy eating behaviors: fad dieting or weight cycling. And we know that eating disorders are already at an increased level among the trans population. So, just kind of these conversations with other clinicians have me wondering, are we making it worse by recommending weight loss without a robust system in place? [theme music returns] So, that's an area of research that I expect to advance kind of out of these conversations happening among clinicians right now.

HOFF: Dr Linsenmeyer, thank you so much for your time on the podcast, and thanks to you and your coauthor for your contribution to the Journal this month.

LINSENMEYER: Thank you for having me.

HOFF: To read the full article as well as the rest of this month's issue for free, visit our site, JournalOfEthics.org. We'll be back soon with more *Ethics Talk* from the *American Medical Association Journal of Ethics.*