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Hilary: [00:00:00] Hello and welcome to the Body Trust Podcast. This is Hilary. And I'm here with Dana.

Sirius: Hi,

Hilary: and serious.

Sirius: Hey everyone,

Hilary: and we're excited to be back with you today. Today we're gonna be talking about ethical care guidelines and GLP ones. We put together a document a couple months ago when we were hosting the GLP one webinar we hosted with Reagan Chastain and Lisa Dubel.

And we made a document to go with it because we have so much fun around here. No, because they're needed. And we'll tell little bit about why. I imagine you can guess. And, but that's where we're, that's what we wanna talk about today. I don't think, you know, as consumers of medical care, I don't know that we're always invited [00:01:00] into discussions about ethics.

It's kind of funny, like ethics, I think, are something that's often reserved for the field themselves. It's a debate within the field themselves. And I think consumers would be great additions to those conversations despite not being invited in. And especially fat folks know a lot about what it's like to receive medical care that's ethical and supportive and medical care that is not, and how that impacts their trajectory in me in healthcare.

So it's what we're here to talk about today.

Dana: There was something you were saying that made me think of how Reagan describes her work as being an expert in how the weight loss industry has infiltrated the healthcare industry. And so when we think about ethics, that's where my head immediately [00:02:00] goes. Mm-hmm. Is considered ethical care for fat people.

Hilary: Mm-hmm.

Dana: And how it's so weight centric

Hilary: Yeah.

Dana: And people's imaginations are so limited and the kind of care that can be provided that we're hoping these ethical care guidelines can assist with that a little bit.

Hilary: Yeah. It's a conversation that's, that's not happening. There's a lot of conversations that aren't happening that need to be happening, but tend to get put to the side or deprioritized around ethics.

And, you know, one is about how we show up to care and ideas of body sovereignty and a choice and who gets that and who doesn't. But I also think about other parts of medicine like research. You know, how, how even though researchers have to disclose you know, who and [00:03:00] what, what is paying for their research and their work or, you know, it's not something made obvious to the public.

Public has to go looking for that kind of information. So there's, there's all kinds of ways where ethics are not opaque. Is opaque the work order I want. Yeah. And we do get to be concerned about that. And it's not, I think, you know, sometimes when we start talking about these kinds of things, like people's conspiracy theories, bells start going off.

And that's not what this is. I remember seeing someone debating on a Facebook post, somebody had reposted something that Dana had posted about the deaths so far from GLP ones. And then it was a dietician that reposted, another dietician jumped on. It was like debating the usefulness of even Fen at this point and kept [00:04:00] listing study after study after study.

Yeah. That shows something about Fen that she thinks is useful. And she's, you know, she was kind of insisting like, have you read the research? And I, you know, I just looked at the research and I said, no one will read this research. I mean, one, because it's research and nobody really, not many people do that.

But second, like, is there any nutrition research that isn't dirty? There's not a lot, you know what I mean? Like it's, that isn't about being sponsored, that isn't paid for by a food company or a pharmaceutical company or a medical company. Like I just, I, I just noticed my reaction. I was like, I don't know.

I think a lot of times that kind of thinking is wasting my time.

Sirius: Mm-hmm. I think one of the hard things about that too is that ethics, like morals are pretty relative. And [00:05:00] what might be ethical in one realm is not ethical in another, and everyone's. Ethical and moral frameworks are so different.

Mm-hmm.

And our approach to what is ethical around fatness, I think becomes really complicated because our culture continues to understand fatness as a moral issue. And that fat people are failing at morality in some very specific ways.

Mm-hmm.

And that, that their failure at being moral is up for comment, debate, and advice by the broader culture,

Hilary: and I would even say redirection.

Mm.

Sirius: Mm-hmm. Mm-hmm.

Hilary: You know, like influence. I've been watching this and thinking about this lately in regards to people and like, when they don't have enough money to pay bills and how, how quickly [00:06:00] the need to intervene and educate and get paternal. And treat them like they're unethical, happens almost immediately.

Like there's a stance we take and it's, it feels in some ways not all ways parallel to what we do with fatness. Like the whole world feels like it's okay to come and it's okay to educate that they know what's going on.

Sirius: Yes. And I think because of that, the questions around like, is, is all nutrition research dirty, like through the lens of this culture and its anti-fat bias.

Yep.

Hilary: Right? Yeah. Thank you. Yeah. Yeah.

Sirius: So like what do you I don't, I, I think it makes it hard to figure out where do you find grounding and where do you find your footing?

Hilary: Yeah,

Dana: yeah. Well, and where weight loss intersects in nutrition [00:07:00] research is particularly. Sketchy.

Sirius: Mm-hmm.

Dana: Anything, I mean, there's, there's the fact that if you have a study and you want funding, attach weight loss to it somehow, and you are more likely to get the funding, then you are if you don't attach weight loss to it.

So there's that. And then yeah. If weight loss is an outcome, yeah. Mm-hmm. It's definitely biased and yeah. I mean, I did, I'm so glad I did not see, I did see that comment on Facebook.

Hilary: Mm-hmm.

Dana: I was like, what? So, and I never, it clearly escalated somewhere and I never got called back to it. Yeah.

Hilary: I haven't glad that there's been much response to that.

Repetitive of Fen research. Like it [00:08:00] didn't really warrant a response, you know?

Dana: That feels absurd.

Hilary: It does. It does.

Dana: I, we were, we,

Hilary: so were

Dana: you alive then? Were you like,

Hilary: and this is a post about deaths. About deaths, and there was also deaths from Fen.

Sirius: Yeah.

Hilary: And so I'm like, I'm glad that you enjoyed your experience with Fen.

And I imagine you are also equally defensive of your experience on GLP ones, even though that's not what was said.

Sirius: It's

Hilary: just my, the, you know, the therapist in me goes there first.

Sirius: Mm.

Hilary: But why, why? That's the other thing is like, we don't really have to be emotionally honest about this stuff when we can defend it on some moral principle like morality.

I mean, I mean it works, but morality. Trumps emotional transparency all the time. I,

Sirius: I think my forever answer to the question [00:09:00] of have you read the research? I is, yes. Have you?

Hilary: Yeah. Right

Sirius: there, there, there may be things in my life if I'm willing to jump into some comments on the internet, you better believe I've done my research and I know what the fuck I'm talking about.

Hilary: You're good like that. Mm-hmm.

Sirius: I'm, I'm not gonna, and, and I know, I know that most people who engage in a lot of these conversations, that's not where they're coming from.

Hilary: No. Coming

Sirius: from. So yeah. If I'm gonna take the time outta my day to like get into something, yeah. I'm doing it because I know what I'm talking about.

Hilary: Mm-hmm.

Sirius: That's neither here nor there. What I, I think though, is more important in this conversation. Is there, there's something about. That fenden peace or like defending GI mean that just, especially if the context is around the people who have died from these [00:10:00] things, like that's what we're talking about here.

We're talking about the risk of death among other, you know, there are other risky things about this. And the point is that GLP ones have had a much greater impact than Fen Fin had, and yet, like we're all okay with that. Reagan talked a little bit about that, that the mm-hmm. The weight loss industry and the drug industry have become very good at making us believe that like fat death is okay and there's an acceptable, like there's an acceptable threshold for that.

Yeah.

Mm-hmm.

That's one piece of it, but I, I also think there's this other thing around like, not everyone who tries heroin dies from it too. Like, like just because. You didn't die, doesn't mean it's an okay drug. I mean, I don't know if that person was defending it from the perspective of, I, I took it and I'm fine, but yeah, I don't, I don't know if that's enough of an argument for me.

[00:11:00] Mm-hmm. Mm-hmm.

Dana: Mm-hmm.

What you said made me think of there was like a beam or something on Instagram about all the people talking about hormones. Ask them to name five hormones and what organ they're produced and the, their list of actions.

Hilary: Mm-hmm. Mm-hmm. Mm-hmm.

Dana: Oh my God.

That's a way to shut down the combo.

Hilary: Mm-hmm.

Dana: I mean, I think, you know, one of the things I was reminded of is, as we were talking, is there's reading the studies, there's reading the abstract, and we know that abstracts often do not tell the whole story. And I believe Reagan may be talked about that on the podcast, but but abstracts often do not, you know, tell the whole story.

They certainly do not show the problematics in the story. Do you have an [00:12:00] analysis with which you're reading the studies? Including the, the

money, right, which, that's the Speaking of ethics, one of the first things Reagan does is who are the authors and where do they get their money?

Sirius: And

Dana: what are the conflicts of interests and yeah.

And how much money have they been paid by the industry? And also, you know, it made me think of something that Evelyn Tripoli was talking about when she did this whole webinar on food addiction and how all of these studies that talk about food addiction do not control for hunger.

And when hunger is controlled for, there is no addiction. And yet if you do not know to look at these studies through that lens, you would think that these studies show really, some of these studies may look [00:13:00] like they have really good data, but if you're not controlling for hunger, when you do the, the effect goes away.

So, you know, we can talk about the research and then we can talk about the research and. You know, I think there's different levels and people sometimes that's like people's way of shutting down a combo is like, well, let me just throw a paper in here. I mean, the fact that someone is defending Fen fund in 2026 is mind blowing.

Look, we were alive. Like, don't gaslight me anyway.

Hilary: Well, and you can't, you know, it's not gaslighting fat people. 'cause fat people are, don't know what they're talking about. You know? They're making excuses. They're being dramatic.

Sirius: Mm-hmm.

Hilary: So I think there is an overall sense that you can't really gaslight fat people [00:14:00] or other marginalized people because they don't get it.

Mm-hmm.

Mm-hmm.

So. When we put this ethical guideline paper together, which is free and available, and you can get it from our site, we'll have a link in the show notes

and you're welcome to share it as widely as you wish. And thank you for doing so. You know, so I'm a therapist and I come from a field that's obsessed with talking about ethics.

Obsessed. We're obsessed with ethics. In the therapy field, we struggle to talk about how lots of what we've called ethics is actually like risk management, but well, that's another conversation for probably other nerds. But you know, we are always thinking about how our very presence and what we do and how we do it.

As healthcare professionals impacts our clients, and we're very [00:15:00] aware of the impact of our personhood and our choices on the people that we see. So from that vantage point, as a healthcare provider, when I went to look up ethical guidelines for GLP ones, I found that that's not a conversation at all.

And I'm like, huh, isn't that weird? Don't you have relationships with clients that you know, that you have power when you're in the room with people? And that impacts how they feel and what choices they make, and that your word choices matter. And where you, where you allow your own personhood to make decisions on about someone else's story or tell someone else's story based on your own assumptions and biases, impacts their healthcare, all that kinda stuff.

So no, that's not part of the GLP one conversation. It's not really a part of you know, very mainstream Googleable healthcare. When I looked up [00:16:00] ethical guidelines, what I was noticing is that they were, their frame for ethics was like all around rationing and allocation. So who deserves access to the medication?

Which is so strange that there, that was the end of the ethics conversation that I found. I mean, I think there's some that we can find about informed consent, which we'll talk about a little bit. But for the most part, you know, there's. All these meds are good and they're good for all the people that our decision trees have told us that they're good for.

And we just have to make sure the right people are getting them IE diabetic people over Kim Kardashian, even though that's changed so much since that time. 'cause our dosage and blah, blah, blah, blah blah has changed. So, that was really interesting to notice. So instead of rationing being a [00:17:00] policy, fa failure issue or allocation being a policy, fa failure issue, they're calling it ethical framework work, which is so weird 'cause that just aligns itself with white supremacy and all the pitfalls of that and capitalism and all kinds of things.

So, interesting how little analysis there is around that. And that when direct to consumer marketing drove demand, you know, prescribers faced no accountability for lack of access for people who had been taking the medication for diabetes, et cetera. So who deserves the drug? The amazing drug that's good for everybody if they meet decision tree kind of diagnosis, whatever people are doing back there to allocate the medication.

So when we're thinking about ethics, we're thinking more through, I think a relational frame [00:18:00] like which is central to the work. Dana and I have always done as clinicians that you know, how you relate to your client, how, how your client feels in the room with you and how much autonomy and choice they have is central to ethics.

And so at Center for Body Trust, body autonomy has always been the North Star in everything we do. We do not tell people what to do with their bodies. We do also believe that true autonomy requires complete and unbiased information, excuse me. And freedom from coercion, including the coercions of weight stigma, medical gaslighting, and a culture that makes thinness a prerequisite for dignity.

So we're including those pieces in conversations and in terms of [00:19:00] really opening up what informed consent can look like when GLP-1s are being considered for prescription.

So the context matters.

Dana: Yeah. This, you know, concept of doing no harm.

Hilary: Oh,

Sirius: yeah. Like

Dana: not in the rationing combo at all. Doing no harm.

So that is fascinating. There's informed consent, and then there's ethical informed consent. And that's really what we're hoping this document

Sirius: mm-hmm.

Dana: Helps people have ethical conversations about informed consent.

Sirius: Yeah.

Dana: Rooted in, you know, the belief in our body, autonomy, and also [00:20:00] our duty to do no harm.

Hilary: Mm-hmm. So maybe you're a provider listening to this and you're thinking. About the conversations that you're having with clients that feel difficult or not really rooted or centered where you'd like them to be, because they probably feel really it's, it's probably hard to pull folks back from their request for GLP ones and have this, this very deep informed consent conversation in the 10 minutes you're allotted to do that.

Or maybe you're someone who's considering GLP ones and have been looking for good information. But regardless, you know, we are trying to make informed consent a little more clear. and We have [00:21:00] eight principles that we've defined in this document that we think create conditions for more grounded or rooted informed consent.

And the first one we've been talking about, which is the context matters that the GLP one demand didn't arise in a vacuum and that there's a \$76 billion, probably more than that now. Weight loss industry and social media pressure. And the fact that the same system offering these meds routinely deny fat folks basic preventative care, surgical interventions, et cetera, et cetera.

Dana: Unfortunately, I don't think the majority of providers have an analysis on these meds to really think about the context and why so many people are choosing this or feeling drawn to choose this. Yeah. And how to actually, [00:22:00] because I think because of the lack of information, really good information out there is hard to come by compared to the, the literature that's being spoonfed to them by the companies.

Hilary: Mm-hmm.

I would guess also the majority of healthcare providers aren't super comfortable with navigating conversations about the impact of anti-fat bias and weight stigma. Weight bias and how and you know, I imagine it's in the room a lot, that folks are taking these meds , to mitigate their experience of anti-fat bias and weight bias in the world.

But I'm also thinking there's probably not a lot of language available in that conversation between provider and patient to bring that to light in a way that isn't really asking people to acquiesce.

Sirius: I think [00:23:00] also there's a piece around. Is this even a provider who is exposed to anything about these drugs, right?

Mm-hmm.

We, yes. They're, they're ubiquitous in the culture. Yes. If you're, if you're a doctor at a certain kind of practice, you might have even ran across a drug rep with samples or something like that.

But so many folks are getting GLP ones from other sources, shall we say.
Mm-hmm.

Mm-hmm.

Whose sole function is to sell people GLP ones? Yeah. So their, their exposure or interest in this is even less than the average doctor, I would say, or the average provider. The average clinician.

Mm-hmm.

And so then, you know, then it does kind of come back to what information are we also putting in the hands of the people who are interested in these drugs or trying to take these drugs.

As much as these ethical care guidelines are [00:24:00] for folks who are providing, like, I think it's also gonna be very helpful for folks who are questioning whether or not they should take these drugs. These are, these are also questions that you could ask a provider.

Hilary: Mm-hmm. And

Sirius: it, and like, it's very possible.

You will not get answers of any kind, good or bad. And that's data too.

Hilary: Yeah.

Sirius: Yeah. Yep.

Hilary: Yeah.

Dana: And because this is such a different, maybe it's, it's not the way these medications are talked about by the, the dominant culture, then we get deemed as being so negative. Like, like your, your ethical guidelines are so.

Sirius: Such a downer.

Dana: Such a downer. Where's my trumpet? [00:25:00]

Sirius: Can't

you

Dana: just support

Sirius: people? Yeah.

Dana: Oh, I

always found it odd and I imagine this is something that many providers who are having conversations with folks about these medications, I know at least for weight loss, to get weight loss surgery, you have to show that you've had multiple previous unsuccessful attempts at weight loss at, at quote unquote behavioral weight loss.

So I'm like, okay, so, so there's no, no data to show that behavioral weight loss works, but we want you to show that you've tried something that doesn't work in order to get this thing that maybe won't work either.

Sirius: Mm-hmm.

Dana: Which connects with several things [00:26:00] on our list for discussion today is like that weight cycling is the mechanism, right by design, you know, weight loss on weight, regain off that is cycling and that they are rebranding.

weight Regain as a relapsing, remitting condition, even to make up for the shortcomings of GLP-1 medications.

Hilary: There's a lot of gaps.

You know, I think the way the this has been positioned in the market, the way it's been rolled out to providers has just allowed a lot of things that could

enhance a more ethical conversation to be steamrolled. We talk about in the document how there's no eating disorder screening, where the fuck are eating disorders, honestly, [00:27:00] so basic.

Sirius: Mm-hmm.

Hilary: So it leaves providers and folks kind of woefully disconnected and under informed about, about the impact of eating disorders and how they may be occurring within the very context, someone seeking GP GLP ones and nobody seems to care.

You know, nobody really wants to let go of theirs, that's for sure. At least in this context.

Dana: And the risk. The risk to somebody who's had a history of an eating disorder or who has an active eating disorder, who is prescribed these often, sometimes vis-a-vis, you know, male order GLP ones. Then you have a subset of people who develop the eating disorder while on the medication.

And then today I even saw a story [00:28:00] of how they're noticing more and more people, you know, dropping weight and, and then not feeling like it's enough and then manipulating their behaviors to keep losing weight And mm-hmm. In that you know, anorexia, we used to see that with people who had weight loss.

Some, a subsection of people who had had bariatric surgery would end up with subtype of anorexia that I think was really spurred on by the surgery itself.

Hilary: And I think there's a number of incidences I've talked to folks about or heard about where folks, you know, lose a lose weight on a GLP one and then wanna keep going and then are approved for like just a weight loss surgery in order to really reach some kind of goal weight, even if they've already lost the, you know, [00:29:00] percentage recommended to, to improve their blood sugar or whatever stuff they say to us about this.

Mm-hmm. You know, it's a lot of

anti-fat rhetoric disguised of course, as the pursuit of health.

Sirius: Yeah. Not to be a broken record, but. I mean, part of the reason why eating disorders aren't part of any of, of the conversations around GLP ones is because a lot of people think that fat people probably could, could develop an

eating disorder and it would be okay. Yeah. Mm-hmm. They need that. They deserve that.

That, you know, again, the moralizing mm-hmm. Of fat bodies is such that if you were to develop an eating disorder, like wouldn't that be a benefit anyway? [00:30:00] Wouldn't, that's the frame that most people have around your body and bodies like yours. Of course, GLP once killing a bunch of people is not gonna be a big deal.

Dana: Mm-hmm.

Hilary: Mm-hmm. Yeah.

Dana: Well, and it's like this quote I put up on, social media last week that I got some responses to was about the hold on a sec. It's about how a child is something like 242 times more likely to develop an eating disorder than diabetes.

Hilary: That.

Dana: 242 times.

Sirius: Mm-hmm.

Dana: More likely

to develop an eating disorder than diabetes. [00:31:00] And yet we have all of these parents obsessing about sugar

and eating disorders. In my post I said, eating disorders are life-threatening conditions, and they killer of teens and young adults, and yet we're threatened over here about diabetes. It's

absurd.

Hilary: Oh, that's absurd. And wildly misunderstood.

Sirius: Yeah, I can't I'm having a hard time sort of pro processing or understanding that and this is not the first time I've heard that at all, but just sort of thinking about it right now it's just really hard to square the idea that this

thing that we know, we know is deadly for people, for [00:32:00] children eating disorders, we know that.

And that's sort of put up against diabetes, which is.

Can, can absolutely can kill people. But there have been, there have been so much infrastructure built around making sure it's a manageable disease for people.

Dana: So treatable.

Sirius: So

Dana: treatable. So like vastly different than treating an eating disorder. Yeah. Like night and day.

Yeah.

That should be my new, don't steal this. Anyone Remember that, that parenting style. Calm, calm the fuck down.

Sirius: Mm-hmm.

Dana: But I make, gonna make it about food. Calm the fuck down.

Like I, [00:33:00] I had a, a pretty like viral post about calming the fuck down about. Halloween candy parents like I, 'cause I had just heard about that parenting stuff. I was like, let's all calm the down about the Halloween.

Sirius: Mm-hmm. Mm-hmm. Mm-hmm.

Dana: We were talking about the risks and eating disorders and how they're often not considered a really downplayed or weight loss is prioritized over risk of eating disorders because of the way we framed fatness in this culture.

Sirius: Mm-hmm.

Dana: Mm-hmm.

Sirius: Mm-hmm.

Hilary: So. One thing we are often advocating for in our training center around is non-weight focused care. And [00:34:00] non-weight focused care can still be about help, but it doesn't necessarily have to put weight first. So, in our discussion of the guidelines on how to do this more ethically, you know, we, we wonder, we wanna imagine what that would look like in, in a scenario that involving prescribing GLP one.

So treating, we wanna treat the person, not the number. We're not trying to delay care for actual conditions while waiting for weight loss, you know? The number of people who don't get to have a knee surgery, but they're willing to do weight loss surgery on is notable.

Sirius: Mm-hmm.

Hilary: And are clinical spaces even set up anticipating fat folks to be there?[00:35:00]

You know, they're chairs that fit folks usually. I think more so that happens, but you have a bunch of weight loss literature in your waiting room. Are your nurses and healthcare providers talking about dieting in the hallways? Do you know where your larger blood pressure cuffs are?

Can people be comfortable in your office?

And can you treat PS like you expect people of all sizes to be there?

Then what is the conversation that happens in those offices about GLP ones

and how might they differ from

other places? Like what happens when fat folks feel like they aren't having to have their defenses up even [00:36:00] when they're going in for a GLP one?

Sirius: This, this piece I think is one of the hardest for folks to get, and also the lowest hanging fruit. And it, it, that flummoxes me like, it, it like, whenever I have to think about this, it's sort of hurts my brain a little bit.

Hilary: Mm-hmm.

Sirius: But there are some very simple things that that. Individuals and organizations can do around providing weight informed healthcare or weight inclusive healthcare, right?

And you name some of those things. And these, those things are structural procedural, right? Like, we're not even talking about changing the hearts and minds or shifting people's perspectives,

right?

It's do I have the equipment needed to meet the needs of my patient base? And if the [00:37:00] answer is no, and you feel justified in the no because, well, they're fat, like that's not okay.

Like, that's really problematic. But it, it, it's, I, it's, it's just really hard for me to continue to have to understand that it, these are actually very easy fixes that people refuse to do

Hilary: that piece. So demoralizing.

Dana: It's just, it's so easy to do it. It's, it's, it's not hard.

Hilary: There is, there are alternatives where we do not have to, you know, just as I was just saying, like, let's not focus on weight solely, you know, and we're talking to people about what their options are.

What would the world be like if one of the options was to say, you don't have to do this dieting thing anymore.

Sirius: Mm-hmm. [00:38:00]

Hilary: People live fulfilling happy lives in all size bodies.

What would that be like? Can imagine hearing that at a doctor's office.

Dana: I know earlier, I'm so glad you said that because it reminded me of what this thing that popped in my head, which is how many people would, you know, what would it be like if people arrived to the appointment and there was a weight inclusive zone poster on the door?

Yeah. There was just something about when you arri, when you walk in the door, if you were met differently, how many, I mean. What would the conversation be like? Might the conversation not even be on the table if mm-hmm. If people were met with si a sign and walked into a space that was like, you know, [00:39:00] not just all are welcome here, but this was made with you in mind.

Sirius: Mm-hmm.

Dana: We expect you to be here. And how it makes me think of people I used to see in our practice on Williams when they would see that on the front door and how it just made their shoulders drop and exhale. And,

I mean, I think there's a lot of training that goes into being a provider who really provides that kind of care, but you can't just put a sign up and, you know, be, be doing good care around this, but. How

Hilary: were, but even time counts. Yeah.

Dana: Yeah.

Hilary: Mm-hmm.

Dana: Yeah.

Hilary: Mm-hmm.

Dana: Just basic acknowledgement.

Sirius: I just

this, I find this so depressing.

Hilary: This is the hard one.

Sirius: When [00:40:00] you said, what if patients didn't have to deal with anti-fat bias in the context of their care? My first thought was, well, people lose so much money.

Hilary: Well, yeah. Say more about that.

Sirius: The, the insurance companies. The drug companies? Mm-hmm. The providers themselves. Gosh, there's, there's just so much money bound up in, whether you wanna call it the weight loss industry, the weight loss industrial complex, or even if you want to just sort of name it as people being invested in your shame and degradation.

Like there's, there's just a lot of money tied up in that. And, and if we didn't engage with healthcare on that level so many people's fortunes would fall in the process.

Mm-hmm.

And we just, we can't have that.

[00:41:00] Mm-hmm.

I mean, not in this day and age. Mm-hmm. There's so, so many threats towards the, the billionaire and the mil.

I mean, the, who cares about the millionaire class? There's so many threats towards the billionaire class that we definitely shouldn't add this one. Abs Absolutely not. They are, they are the most important resource that we have and we would never want to threaten them in any way or make them obsolete

or question their supremacy in our culture. Man. I, Hmm, I should, I'm gonna stop talking now.

Hilary: So

I'm thinking about clinical red flags a little bit. Like I, this has been, you know, this conversation is a lot, it's kind of wide and. Frustrating, sad. [00:42:00] And I know some of you out there might be like, well, what do I do with this? You know, how do I, what do I do? And that might come from providers who are listening and folks who are seeking care or considering GLP ones.

And we, I, you know, we, yeah, we don't really want you to negotiate away your humanity in exchange for GLP ones. And so

I think if I was looking for a provider, I would want to know someone cared about whether or not I had an eating disorder. And if they don't, you might mention, do you really not ask about that? I would think if BMI is their primary health indicator, they're missing a lot about you and not really paying attention

deeply to who you are and what your body in particular needs, which isn't the same as everybody [00:43:00] who's the same BMI as you.

There might be a lot of reasons why you might wanna go to GLP one online prescriber. The exhausted person in me can see you and be like, yeah, I get that. You know, and if you do that, I want you to have other people on your side around that. You know, I think there's a lot of folks in fat liberation communities who aren't telling people that they're doing that or aren't telling, wanting to tell their healthcare providers that they're, that they've done that separately from.

You know, their primary care or the people they usually see. And I don't know, you know, I can't be the one to tell you who's safe to tell in your life or who isn't safe, but just tell somebody, you know, somebody who's interested in your body [00:44:00] sovereignty. Somebody who's, who's interested in your body story, ideally can hold some complexity.

There's, if you don't have anyone in your life, there's a lot of body trust providers on our directory who would be really great to talk to about that. And you know, I, I think you deserve to know where folks are getting kickbacks for prescribing you something. There's probably a longer list I could make here, but just in the interest of how much I know people who listen here care about ethics and fat liberation, you know that these are some things we can start asking for from our providers.

In the spirit of more ethical care for everyone[00:45:00]

and providers. If you wanna feel like you're doing something in the spirit of fat liberation, even if you can't interrupt the speeding train that is GLP ones, you can just offer this information at an appointment. What is your eating disorder history? Tell me about what kind of care you've had for that.

I'm not as interested in your BMI as I am about other things that you wanna tell me about your experience in your body. I'm gonna be in relationship with you while you are on GLP ones, and I'm interested in how it'll be the good, the bad, the not so good, and disclose whether or not your paycheck is tied to whether or not you prescribe this GLP one.

To me, if we're just kind of getting down to the core of ethics and client care and patient care, that should be something we all do.[00:46:00]

Dana: I think about too, that

I know a lot of providers I talk to and that I do supervision and consultation with are feeling really burnout out on the conversation.

Sirius: Hmm.

Dana: Like just tired of talking about it. I know there's burnout in the culture, you know, people are tired of hearing about it, then it's in our offices and we can feel tired of having conversations about it.

And, and sometimes providers can have pretty hard lines about this stuff. And I just wanna encourage folks to, yes, we have an ethic of doing no harm, which includes sharing information with people that they may not have access to, and then supporting them in whatever [00:47:00] decision they make.

Sirius: Mm-hmm.

Dana: Even when we disagree.

And I've, I think that's, that's, I know that's happened for even people who come to our work in Body Trust and they often have one foot over here in Weight Watchers and one foot over here in Body Trust, right? They, they've got one foot over here on a GLP one, and then they're coming to Body Trust because something here resonates.

And then I hear truth and, you know, we, we make space for all of that. Some providers wanna have a hard and fast line. Like, if you want weight loss, great, but someone else will do that for you or with you. And I mean, yes, on some level that is true. And like the harm that happens if they go to another provider is far greater than if they go on a GLP one.

And you are there to help them have the conversation and a, and a question that we [00:48:00] offer in. I believe in the ethical care guidelines. I know there's some scripts and things is like how would we know, what would be some of the warning signs that this isn't working for me? You know, or for you, you know.

So if you're thinking about taking it and you're concerned and you haven't started it yet, what would be some signs for you that would make you go, okay, I don't think this is good for me. Or what, what would be some of those warning signs? And that's what we can ask as providers is how would we know if we're getting into sticky territory?

I mean, it feels sticky regardless, especially if you have a, a history of an eating disorder. But how do we know when we're getting into more dangerous territory, what would be some of the signs? And I do think that there is a subsection of the population who, who is not going to be able to move on [00:49:00] with their lives without trying the medication.

Sirius: Mm-hmm.

Dana: That could be a great question too, like what would you need to do to be able to move on from this and quit stewing about it, but make a decision and that, you know, I could imagine some that could be a, an evocative question too. But there are there the way these are being, I do think that's shifting a little bit.

I don't know serious, we probably don't have time for your, your medical minute, your GLP one minute on where we're in pop culture, but it does, I do think we're hearing more about these outcomes and things more and more, you know, adverse events and maybe some of the disillusionment is the tides are turning a little bit and I [00:50:00] still think we're in such a seductive phase that some people will just have to do it before they can move on.

Sirius: I think you're right about that. We are in a moment where the, the stories, the warnings, the negative experiences, those are all starting to show up in the public consciousness about GLP ones. But it's not enough to change the demand or the interest. Not yet. That could change. But right now I feel like all of that is treated more as a curiosity or, or at least, well, that probably won't happen to me.

That didn't happen to my friend.

Mm-hmm.

That sort of thing.

Dana: Mm-hmm.

Sirius: Yeah.

Dana: And we'll have more people on these long term, you know, so we'll be learning more and more about. We are hearing more that food noise returns, [00:51:00] even if you stay on the medication, we're learning that weight regain happens even if you stay on the medication.

Sirius: Mm-hmm.

Dana: There's a plateauing and a regain.

So there's more information coming out as time goes on.

And in the meantime, we will be here.

Hilary: We'll, we certainly will. And this GLP one Ethical guideline paper is available to you and the show notes for your consideration, or if you wanna dig a little deeper or share it with your providers, coworkers, et cetera, please do.

Sirius: I, I just feel like I would be remiss if I just didn't remind folks that, you know, again, bodily autonomy and all things, you [00:52:00] have to make the best choices for you and your body.

Hilary: Yes.

Sirius: At the same time, because multiple things can be true at the same time. It's impossible to change systemic oppression through individual choices.

There has to be collective answers, and our collective answer on anti-fat bias cannot be, well, let's all lose weight then.

Hilary: That's right.

Sirius: So

Hilary: exactly that.

Sirius: I have not figured out how those things always come together, but I also know I don't have to be the only one trying to figure that out. And that is also part of our [00:53:00] collective work, is to try to bring how, how do, how do, how do those things function together? Both things are happening already. How do we make sure that they function together?

Hilary: Yeah. Mm-hmm.

Dana: Mm-hmm.

Well, more on that and your freedom and desire sock.

Sirius: Yes. One day. Yes. Prob, prob probably the next essay, which I'm guessing will time well with this episode, but mm-hmm. We'll see about that.

Dana: Mm-hmm.

Hilary: Thanks for tuning in everyone. We appreciate you being here. And if you haven't listened to our interview with Reagan, we strongly recommend you do that. I think that will context. Thanks. Being.