



The Invisible and Insidious Enemy

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The severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) virus is invisible, harmful, and indeed often lethal, and spreads rapidly. However, for all of us in the throes of this pandemic, is there something else lurking in the background with the same characteristics, and then some? I previously reported the “clash of the two pandemics” to describe the bi-directional relationship between obesity and COVID-19 [1]. However, it appears that there is an element common to both conditions which on top of being invisible and harmful and spreading rapidly, is also insidious—stigma and discrimination.

The term “stigma” was first introduced by Goffman to describe undesirable visible characteristic features [2]. Since then, the definition has evolved to refer to the negative association between a person or group of people who share certain characteristics or have been affected by a specific disease [2]. Stigma may in turn lead to discrimination, which is the unfair or prejudicial treatment of these groups of people [2].

Weight stigma is common in people with obesity and has multiple far-reaching adverse consequences on physical, psychological, and social health—the various components which make up the holistic definition of “health.” Weight stigma has clearly worsened during this pandemic due to a number of factors such as increased stress, negative affect, and rumination during the pandemic, which could be collectively summed as the “pandemic effect” [3]. Sutin et al. [4, 5] found that weight discrimination pre-pandemic was associated with increased depression, anxiety, stress, and loneliness, as well as decreased trust and deterioration in the quality of close relationships during the pandemic. Pre-pandemic weight stigma was also associated with binge eating, eating as a coping strategy, and decreased physical activity, all of which worsen the problem of obesity [3]. To further illustrate the gravity of the

situation, weight stigma predicted these negative health consequences more strongly than the actual weight or body mass index (BMI) [4, 5]. In addition, it is well-reported that people with actual or suspected COVID-19 infection have been stigmatized [2]. Therefore, people with obesity and COVID-19 are not only at increased risk of severe COVID-19 and mortality, but also a potential catastrophic deterioration in mental health [1].

People with obesity are likely to delay or avoid seeking necessary medical care for both infectious and non-infectious conditions because of fear of judgment and humiliation experienced in healthcare settings [6]. With specific reference to COVID-19, this could lead to delayed diagnosis, worse prognosis, and increased viral transmission [6]. In the same vein, it is likely that there would be a decrease in seeking medical attention for obesity and related comorbidities.

Although the association between obesity and COVID-19 is well-described, it is important to avoid over-emphasizing attribution of COVID-19 disease burden, severity, and death to obesity alone, as it leads to further stigmatization and discrimination of people with obesity [7]. Thus, public campaigns launched with weight loss as a key strategy to combat COVID-19 might inadvertently worsen this issue. Given the precarious balance between appropriate weight loss and the negative consequences associated with stigmatization, it might be wise to advocate simple infection control measures such as wearing a mask, regular handwashing, and social distancing to decrease the risk of COVID-19 instead. The mass media and social media also have an important role to play—for example, social media posts which make fun of people with obesity and over-eating such as the “quarantine 15” perpetuate the problem.

Moving to our local experience, although COVID-19 first hit our shores in January 2020, the issue of stigmatization and discrimination initially appeared to be under control until new clusters of infections resurfaced in May 2021. Shortly following this, numerous reports began to surface of healthcare workers (HCWs) being evicted from their places of residence, not being able to get on taxis or private hire cars, and being shunned by members of the public.

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There could be a number of reasons for these worrying observations. Firstly, these new clusters of infection occurred despite a successful vaccination program and vaccination of a significant proportion of the population. The World Health Organization (WHO) has described that COVID-19 is associated with stigma due to three main reasons—it is a relatively new disease for which there are still many unknowns, the fear of the unknown, and the ease of attribution of this fear to other individuals—which provides a relevant framework to account for our observations. New clusters of infection despite vaccination are a clear indication that there is still much that is unknown regarding COVID-19, which leads to the natural response of fear. A second important reason was that one of the earlier clusters occurred in an acute hospital, which could lead to the perception that the new virus outbreak “originated” from HCWs—based on the aforementioned framework, this likely led to an attribution of fear to HCWs.

One of the key roles of HCWs during this pandemic is in tackling this issue itself, through measures such as sharing accurate information, respecting and protecting the privacy of patients, and raising awareness about COVID-19 without increasing fear. However, what about when the tables are turned on us, when we are the subjects of stigmatization and discrimination? Stigmatization of HCWs, although not a new phenomenon, is associated with increased symptoms of anxiety and depression [8], which in turn compromise our ability to care for our patients at a time when this is most urgently needed—particularly patients with obesity.

How do we stop this seemingly inexorable vicious cycle? Firstly, the timely dissemination of accurate, clear, and sensitive information on the pandemic is of utmost importance. The media must ensure the use of non-discriminatory language, such as “people with COVID-19” and “people with a possible diagnosis of COVID-19,” rather than “COVID-19 cases” or “victims” [9]. Similarly, the use of terms such as “weight,” “excess weight,” and “BMI” is far preferable to “obesity,” “fat,” or “excess fat.” Although public efforts to combat obesity should continue, as described earlier, the primary objective of such campaigns should be directed at the improvement of general health outcomes, rather than to specifically reduce the risk of COVID-19. The authorities should not hesitate to take harsh punitive measures towards those who engage in activities which undermine social unity such as hate crimes and spreading fake news.

One of the tools in our armamentarium which I had previously described in our bid to “sharpen the saw” to prepare for the “new normal” is telemedicine [10]. Telemedicine provides the opportunity for people with obesity to receive care with less perceived stigma than during face-to-face clinical encounters, and thus is a potential solution to the issue of delayed or decreased seeking of medical attention [6]. Future large-scale

studies could be performed to clarify this issue—for example, to assess the time from symptom onset to presentation in patients with obesity [6]. The essential role that HCWs play should be emphasized and the due recognition and appreciation given. Mental health support should be provided to vulnerable groups such as patients with COVID-19 and their families, and indeed, HCWs at the frontline. We must support each other to collectively do our best to combat this pandemic, and a big component of this is through addressing this “invisible and insidious enemy”—stigma and discrimination.

Declarations

Ethical Approval This article does not contain any studies with human participants or animals performed by the author.

Informed Consent Informed consent does not apply, as this article does not include data or description of any individual patient.

Conflict of Interest The author declares no competing interests.

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