

First do no harm:

reconsidering our approach to weight in primary care

INTRODUCTION

Weight stigma may be defined as ‘the social devaluation, denigration, and marginalization of’ higher-weight individuals.¹ Weight stigma is well documented in the healthcare context, including in general practice, with implicit and explicit anti-fat biases consistently found in primary care physicians and serious implications for quality of care and patient outcomes.² Weight stigma is not only directed at patients. As a higher-weight doctor in the UK, I (Sebastian CK Shaw), have experienced numerous incidents of being publicly shamed or pointed to as a cautionary tale by colleagues in both primary and secondary care settings. Such experiences are validated by the recent findings from a North American study, in which 87% of doctors were found to harbour implicit anti-fat bias where higher-weight colleagues were concerned. Interestingly, when asked explicitly, most participants reported low levels of bias toward higher-weight doctors, suggesting that many may be unaware of their biases.³

THE CURRENT STATE OF PLAY

The situation seems unlikely to improve, as weight stigma is not only entrenched in our everyday lives, but also further fostered during medical education. Healthcare education and discourses surrounding obesity promote a view of fatter as lesser and often seem to reduce the complexity of body weight to a simplistic, individual-blaming rhetoric.⁴ Additionally, it is not unusual for medical students to observe denigration and discriminatory treatment of higher-weight patients by faculty and staff, contributing to the (not so) ‘hidden curriculum’ that promotes implicit, and in some cases explicit, anti-fat bias in our medical workforce.⁵ In one UK study exploring beliefs in negative stereotypes about obese people, only 2.1% of medical students expressed neutral or better attitudes towards this group.⁶

Weight stigmatisation should have no

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place in a profession whose ethos is to first do no harm. Experiences of weight stigma are associated with physical and psychological morbidity and mortality, independent of body mass index (BMI).¹ In young people, experienced stigma is associated with increased suicidality — even labelling young people as ‘overweight’ is associated with disordered eating, unhealthy weight-control behaviours, and long-term weight gain, independent of baseline BMI.⁷

Unsurprisingly, weight stigma among healthcare providers is linked to healthcare avoidance in patients, including under-utilisation of preventive health care and screening.² And lest one should believe that stigma serves the patients’ best interests, motivating them to ‘do something’ about their weight, evidence consistently demonstrates that stigma is more likely to lead to increased allostatic load, higher prevalence of chronic diseases, and further weight gain, again, independent of BMI.¹ Even encouraging higher-weight patients to view their weight as a problem could have paradoxical effects. Evidence suggests that chronic weight dissatisfaction over time predicts increased risk of developing type 2 diabetes mellitus, even when controlling for BMI — the effect being greater than having a family history of diabetes.⁸

Our training and praxis seem to encourage a culture of ‘othering’ of higher-weight individuals, that seems to give us licence to treat higher-weight individuals as a problem or a burden. However, the foundations on which our attitudes towards higher-weight individuals apparently rest may not be as solid as generally thought. Research has demonstrated that high-weight status may

not be the strong determinant of health it is generally considered to be, and that weight loss is not required to improve metabolic health.^{1,7} It is also unlikely to happen. Diets are ineffective in the long-term and frequently produce paradoxical results, worsening health and driving further weight gain.⁹

While body weight naturally varies across a continuum, as with other physical characteristics, the intersectional nature of obesity prevalence speaks to the social determinants of health¹⁰ — an issue that cannot be solved by individual behaviour change. That many clinical guidelines continue to treat obesity as a disease, the solution to which is located at the level of the individual patient, can at least in part be attributed to powerful vested interests and a narrow focus on an evidence base that is limited in its scope, that takes pathology as its starting point, and continues to publish in an academic echo chamber, as demonstrated in O’Hara *et al* (unpublished data, rhetoric versus substance: how new are Canada’s ‘new’ obesity guidelines? 2021), and O’Hara and Taylor (2018).¹¹ This situation is not dissimilar to the field of autism research, which has been revolutionised in the last 20 years through the introduction of the neurodiversity movement, reframing research discourses away from the pathologising lens of deviance and toward one of difference.

Thus, the dogmatic promotion of individual weight loss is likely to be ineffective, damage patient–physician relationships, promote overmedicalisation, propagate weight stigma, and is at odds with a holistic approach to health care and the ethical principles of beneficence and social justice. People have a ‘right to exist in their bodies without prejudice, stigmatization, marginalization, or oppression’.¹

As advocates for our patients, including their holistic wellbeing and autonomy, our training may place us in a difficult position. As physicians, our aim is to centre the needs of our patients, yet we carry a deeply ingrained

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instinct to shield the healthcare system from the long-term economic burden that we have been taught obesity represents. Yet, this role conflict arises from the false foundation that our current weight-centric approaches to individual patient care will produce sustained, improved health outcomes and cost savings to the healthcare system in the longer term.

CONCLUSION

We call for a better understanding and approach to education of the issues and discourse surrounding weight and health. We need to build a healthcare system that acknowledges and aims to eliminate the impact of social inequality on health outcomes, and to recognise that weight stigma perpetuates and magnifies health disparities in already marginalised populations. While diversity-related legislation does not protect higher-weight individuals from discrimination, we as healthcare professionals have an ethically

bound duty to do so. In primary care, we are the gatekeepers to specialist services and are typically patients' first port of call for medical concerns. Let us lead the way in challenging tradition and fostering positive change.

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Provenance

Freely submitted; externally peer reviewed.

Competing interests

The authors have declared no competing interests.

DOI: <https://doi.org/10.3399/bjgp22X718565>

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