Weight stigma an unacceptable burden

Pervasive bias robs patients of appropriate, compassionate care

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A few weeks ago, an obese patient needed a breast magnetic resonance imaging (MRI) scan. It started with a too-small gown and no access to anything larger, continued with MRI coils that would not fit anyone with breasts larger than a C cup, and ended with an entire waiting room exposed to an unsolicited strip show—and the patient was humiliated.

That patient was me: a family doctor who has worked in southern Alberta for almost 2 decades, and a mortified obese woman forced to bare and bruise herself for lack of size-inclusive options.

Being a doctor is always complicated. We simultaneously understand why certain systems exist and how difficult it is to change things, and we know how things should go, if the system were to work as it was meant. Those things—the way it should work and the way it actually does—are often worlds apart.

The same is often true when it comes to obesity, unfortunately. The way things should work, the way we want them to work, is not the way they do work. We want obesity to be treatable. Transient. Manageable. We want to be experts, advocates, guides. But obesity is more complex than we want to admit, and although I do not believe anyone goes into medicine with the intent to harm, we sometimes do just that.

Weight stigma is common and takes many forms: subtle or blatant, systemic or individual. But as my MRI demonstrates, medical stigma against the obese is pervasive.[1] Systemically, it is in the sizes of gowns ordered for a hospital, the types of chairs in waiting rooms, the weight limits of operating room tables and computed tomography scanners, and the absence of bariatric lifts and other mobility aids. But stigma is also in us—when we dismiss symptoms in the emergency department or doctor's office, or when we include a lecture on diet with every Pap test. It is the fear and disgust in a surgeon's eyes when a patient like me needs a procedure. It is ubiquitous, and our current weight paradigm is making it worse every day.[2]

Losing the war on obesity

Recent articles in many medical journals (including this one) document rising rates of obesity across the country and the world. And they are not wrong: obesity is becoming more common, and our average BMI is rising.[3] We have been waging a *war on obesity* since the 1990s—and we are losing. Our interventions do not work, are not accessible, or are impractical for most of the people who need them. They are not practical for society, either; the medications used to treat obesity are unaffordable for most people.[4] We are not prepared as a society for half of the population to need surgery or medication with side effects, complications, and costs.

Our current weight paradigm supports a narrative of people living in large bodies as being a problem. They, personally, are defective. There is a quote from Dr Lindo Bacon, a physiologist, researcher, and author, that reads "you cannot wage war on obesity without waging war on the people who live in those obese bodies." I can confirm this is true. I feel it every time I go to the doctor. Every time I open a journal to read another study about the *cost* of obesity or the newest weight-loss drug. Every time I see an ad for weight-loss programs that are *doctor-approved*. Every time a news story calls people like me an *epidemic*, as though we are diseases rather than people. If you are fat and you do not lose weight, you are made to feel like a failure, with all the shame, distress, and health care avoidance that comes with having failed.

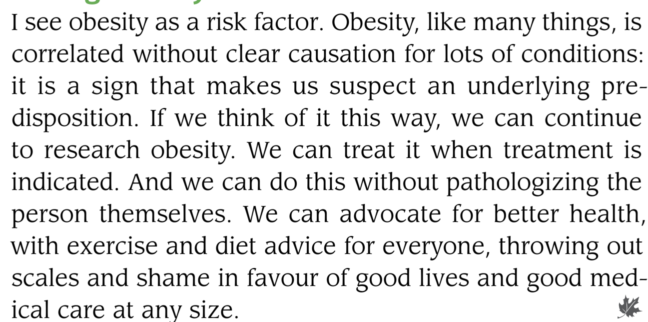
Labeling obese people as sick

Much of this discussion comes down to whether obesity is a chronic disease. The medical paradigm says it is; the establishment claims that acknowledging obesity as a disease allows us to allocate research dollars, investigate treatments, and attempt to improve lives. But it also turns my body into a problem to be solved. Having obesity listed as a disease necessarily labels all fat people as *sick* and supports the fat shaming we see in the media. Follow any fat celebrity on Instagram and you will find *health trolling*, where people say horrific, fat-shaming things and excuse themselves with platitudes, such as, "I was just worried about her health." This also happens in health care.

Obesity is included in the problem list in our electronic medical record system. In some provinces, the government will pay physicians only if we *address* it annually. We are meant to ask about weight in the same way we routinely check in on diabetes or heart failure. That means every fat person, whether presenting with an ingrown toenail, a sexually transmitted infection, or lung cancer, gets a lecture on their weight. It makes it easy for doctors to ignore or dismiss symptoms that might be serious in favour of giving weight-loss advice. If obese people are *sick*, we do not have to build MRIs and operating rooms with them in mind—because they are not *normal* and that is their own fault. This does not have to be conscious to exist as a bias.

Personally, I have had serious medical conditions missed or misdiagnosed because a clinician was more focused on my weight than on my health. I have faced surgical delays with negative outcomes. In the intensive care unit after sepsis had caused dangerous weight loss, I was encouraged to "keep it up." And I am just one example.

Seeing obesity as a risk factor



I see obesity as a risk factor. Obesity, like many things, is correlated without clear causation for lots of conditions: it is a sign that makes us suspect an underlying predisposition. If we think of it this way, we can continue to research obesity. We can treat it when treatment is indicated. And we can do this without pathologizing the person themselves. We can advocate for better health, with exercise and diet advice for everyone, throwing out scales and shame in favour of good lives and good medical care at any size.

Dr Stephanie Hart is a family physician in Okotoks, Alta, with a practice dedicated to sexual health.

Competing interests
None declared

References

1. Phelan SM, Burgess DJ, Yeazel MW, Hellerstedt WL, Griffin JM, van Ryn M. Impact of weight bias and stigma on quality of care and outcomes for patients with obesity. *Obes Rev* 2015;16(4):319-26. Epub 2015 Mar 5.
2. McGuigan RD, Wilkinson JM. Obesity and healthcare avoidance: a systematic review. *AIMS Public Health* 2015;2(1):56-63.
3. Goodarzynejad H, Meaney C, Brauer P, Greiver M, Moineddin R, Monavvari AA. Recent trends in adult body mass index and prevalence of excess weight. Data from the Canadian Primary Care Sentinel Surveillance Network. *Can Fam Physician* 2022;68:128-38.
4. Court E. Prescription weight loss drugs are working, if you can get one. *Bloomberg Businessweek* 2022 Jan 4. Available from: **https://www.bloomberg.com/news/features/2022-01-04/prescription-weight-loss-drugs-for-obesity-work-if-your-doctor-lets-you-get-them**. Accessed 2022 Jul 12.

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