

Questioning the Ethics of Promoting Weight Loss in Clinical Practice

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Résumé de l'article

Cette étude de cas examine la défendabilité éthique de recommander la perte de poids comme traitement pour les patients ayant un indice de masse corporelle plus élevé. La recommandation d'une perte de poids peut être motivée par les préjugés des cliniciens à l'égard des personnes vivant dans des corps plus volumineux, par des perceptions erronées du poids et de sa pertinence pour la santé globale ainsi que par l'absence de prise en compte d'autres facteurs éthiques, tels que ceux liés à l'équité et aux déterminants sociaux de la santé.

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ÉTUDE DE CAS / CASE STUDY

Questioning the Ethics of Promoting Weight Loss in Clinical Practice

Andria Bianchi¹, Maria Ricupero²

Résumé

Cette étude de cas examine la défendabilité éthique de recommander la perte de poids comme traitement pour les patients ayant un indice de masse corporelle plus élevé. La recommandation d'une perte de poids peut être motivée par les préjugés des cliniciens à l'égard des personnes vivant dans des corps plus volumineux, par des perceptions erronées du poids et de sa pertinence pour la santé globale ainsi que par l'absence de prise en compte d'autres facteurs éthiques, tels que ceux liés à l'équité et aux déterminants sociaux de la santé.

Mots-clés

biais de poids, stigmatisation du poids, poids inclusif, déterminants sociaux, cycle du poids

Abstract

This case study considers the ethical defensibility of recommending weight loss as a treatment for patients with higher body mass indexes. Recommending weight loss may be motivated by clinicians' biases toward people living in larger bodies, misperceptions about weight and its relevancy to overall health, and a failure to consider other ethical factors such as those related to equity and the social determinants of health.

Keywords

weight bias, weight stigma, weight inclusive, social determinants, weight cycling

Introduction

Healthcare practitioners may, at times, find themselves recommending weight loss for patients of a higher weight. This action may be motivated by clinicians' biases toward people living in larger bodies, misperceptions about weight and its relevancy to overall health, and a failure to consider other ethical factors such as those related to equity and the social determinants of health. The goal of this case study is primarily to encourage clinicians to reconsider recommending weight loss to their patients. We ultimately argue that a weight-inclusive approach is preferable.

Case Study

Jamie lives with psychosis and is on a mental health leave from work. Working with his psychiatrist, Jamie found a medication to manage his symptoms that resulted in 40lbs of weight gain; Jamie is now fat.

Upon visiting his family physician for an annual check-up, Jamie was given a prescription for semaglutide. Semaglutide is an injectable medication for type 2 diabetes. A one-year trial showed that semaglutide lowered A1c (i.e., a test used to diagnose and monitor diabetes) and resulted in a maximum 12lb reduction in weight (1). The company's website states that semaglutide "is not a weight loss drug... [b]ody weight reduction was a secondary endpoint in clinical trials (2)."

Jamie's A1c is 4.8%, which is normal. The doctor's rationale for prescribing off-label use of semaglutide was: "It's just a matter of time before he develops diabetes because of his weight." Recall that the purpose of Jamie's visit was for a checkup, not weight loss. This scenario is an example of a weight-related microaggression¹ (3).

Maintaining weight loss: practical considerations

A weight reduction of 5% to 10% of body weight for people with a higher body mass index (BMI) is often associated with improved health outcomes (4). Increasingly, and based on the authors' experiences, some patients report receiving advice from physicians to lose weight by eliminating carbohydrates, joining Weight Watchers, etc. These diets do not promote healthy eating as per Canada's Food Guide and/or do encourage calorie restriction that is not sustainable in the long term (5). Moreover, restricting energy intake with or without increasing energy expenditure does not result in long-term sustained weight loss for most people. A meta-analysis of 29 weight loss studies found that more than 50% of lost weight was regained within 2 years, and more than 80% by year 5 (6).

Maintaining lost weight is difficult due to hormonal adaptations that resist weight loss² (7). When weight regain occurs, individuals will often re-attempt losing weight, which promotes weight cycling ("yo-yo dieting") (4). Weight cycling has physical and emotional health consequences (e.g., insulin resistance predisposing people to type 2 diabetes, low self-esteem, poor body image) (8). Furthermore, while a higher BMI is typically associated with greater risk of developing chronic diseases, losing weight does not necessarily result in prolonged life.³ (9).

¹ According to Tylka et al., "microaggressions are the intentional or unintentional verbal, behavioral, or environmental indignities that communicate hostility or negativity toward people who hold less power in society" (3).

² More specifically, body weight is regulated via hormones that increase appetite and decrease satiety in response to weight loss.

³ The Look AHEAD trial (a large multicenter randomized control study with a follow up period of 9.6 years) found that participants living with diabetes who maintained a 7% weight loss failed to reduce cardiovascular mortality in 5145 overweight individuals (9).

Recognizing the consequences of *focusing* on weight loss for people like Jamie leads the authors to question the ethical defensibility of weight loss as a primary clinical recommendation.

Health gains in the absence of weight loss

Systematic reviews and meta-analyses show how health benefits via lifestyle changes can prevent and treat diabetes and heart disease *irrespective of weight loss* (10-13). According to Blair, physical inactivity and low cardiorespiratory fitness may be the most important public health risk factors and not *obesity* itself (14). Thus, we advocate for a weight inclusive approach that accepts size diversity and promotes health and well-being for all by addressing the social determinants of health (15,16). The social determinants that contribute to a person's lifestyle (and to the prevention and treatment of chronic illness such as, diabetes and heart disease) include income, employment, living arrangements, physical environments, education, social status, and support networks (15). Rather than make weight loss the default recommendation when it comes to patients in larger bodies, clinicians can better assist all their patients by familiarizing themselves with how the social determinants influence one's health and wellbeing. Clinicians can then make recommendations that accord with their patients' lifestyles, and advocate for social change.

Addressing criticisms of weight inclusivity: some ethical considerations

In response to the idea that weight loss is problematic for people like Jamie, some practitioners may say: 1) It is irresponsible to *not* encourage people to lose weight given the *obesity epidemic* and/or 2) It is important to help patients lose weight, especially if they make an autonomous request for weight loss.

We have already shown that the first argument is moot because of the impracticability of sustaining weight loss and the harms associated with weight cycling. While encouraging weight loss could be considered compatible with respecting autonomy, we argue that telling patients what they want to hear and recommending a treatment that has a high failure rate is not in line with patient-centred care. Additionally, and according to a 2016 study, the stressors associated with weight stigma and trying to lose weight may be more harmful than the weight itself, leading to maladaptive eating behaviours and increased weight gain (17).

A recommendation of weight loss is likely motivated by sincere intentions; however, biases regarding body image and people in higher weight bodies are prevalent, and these biases may influence a provider's perspective on whether a patient should lose weight. In their discussion of weight stigma, Phelen et al. state that physicians may wrongly and/or unnecessarily attribute symptoms or problems to *obesity* for people who are classified as obese. Additionally, they may fail to refer the patient for testing and/or to propose alternative treatment options beyond simply advising the patient lose weight (18). Conversely, those who are of *'normal'* weight may be overlooked. Another article also notes that "[a] cluster of studies have reported that physicians view obese patients as less self-disciplined, less compliant and more annoying than nonobese ones and that, as patients' BMI increases, physicians are likely to have less patience and desire to help them (Hebl and Xu, 2001; Huizinga et al, 2009)" (19). One of these studies analyzed physicians' perceptions of patient sizes. The study found that physicians treat patients differently based on their size, from which overweight and obese patients receive a lower quality of care (20).

The biases held toward patients of a higher weight may influence physicians to recommend weight loss without considering: 1) the social determinants of health, 2) that weight loss is unsustainable for most, and 3) that positive health outcomes can be achieved without losing weight. All of these factors must be taken into account when considering the ethics of a recommendation. Additionally, communicating accurate and transparent information to patients about weight loss is an important part of providing patient-centred and ethical care, and enabling patients to make informed decisions about their overall health. In order to ensure that an ethical recommendation(s) is made to patients of higher weight (and since patients typically trust their healthcare team's recommendations), we suggest that clinicians ought to reflect deeply upon why they may decide to recommend and/or celebrate weight loss in certain contexts.

Clinical Implications

In order for patients like Jamie to make sustainable improvements to their health, we encourage practitioners to consider the following before recommending weight loss:

- 1) How do I feel about people of higher weight? Do I have potential biases that may be influencing my recommendation(s)?
- 2) Is the patient requesting weight loss? If so, why? Note: If they are requesting weight loss for health outcomes, it may be worth flagging that health improvements can often be achieved with lifestyle changes irrespective of losing weight.
- 3) Is the patient informed about the likelihood of weight regain? Am I being transparent?
- 4) Are lifestyle changes possible given the patient's social circumstances?
- 5) Would a referral to a dietitian help the patient make lifestyle changes?

Contemplating these questions may enable clinicians to more effectively contribute to the overall health of people like Jamie and provide patient-centred care.

Conclusion

Clinicians must reflect on why they may recommend weight loss for some patients since studies have shown that practitioners may treat patients differently based on biases related to their size. As a result of these biases, clinicians may not communicate accurate or transparent information about possible consequences associated with attempting to achieve and sustain weight loss. Instead of weight loss, it may often be more helpful to focus on a person's lifestyle and the social determinants of health. The ethical defensibility of proposing weight loss as a recommendation to achieve certain health outcomes may be lacking in certain cases.

Conflits d'intérêts

Aucun à déclarer

Conflicts of Interest

None to declare

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