Prompting lifestyle interventions to promote weight loss is safe, effective and patient-centred: No

Angela Ballantyne A,B, Denise Steers A,C and Lesley Gray A,B,*

Moral panic – no time to weigh

People, worldwide, are getting larger and this is generating growing moral panic.1 In Aotearoa New Zealand (NZ), one in three adults has a body mass index (BMI) >30 kg/m² (currently defined as obesity), as do one in eight Tamariki.2 Yet, the relationship between weight, health and stigma is complex.3 New evidence shows significant association between higher BMI and lower mortality risk in cardiovascular, coronavirus disease 2019 (COVID-19), critically ill and surgical populations: BMI in the 25 kg/m² and above range is associated with significantly lower mortality compared to BMI in the 18–25 kg/m² range.4 Further, BMI is an inconsistent measure of obesity in Māori and Pacific patients.5 BMI should not be used as a medical diagnostic tool.6 The World Obesity Federation’s position suggests we distinguish between body size/weight and obesity, refraining from using ‘obesity’ to reference a person’s anthropometric metric.7 Obesity is, in some cases, correlated with other root causes that contribute to adverse health outcomes.8 By focusing on obesity, those root causes might be missed. On the flip side, healthy behaviours such as diet and exercise have more impact on mortality than BMI9 – so why are we still focusing on weight?

Current policy in NZ reflects a weight-centred health paradigm (WCHP) – an approach to health focusing predominantly on body weight, either through a focus on individual interventions (weight loss behaviour modification, pharmacology or surgery) or on the obesogenic environment.10 The WCHP is contested due to lack of evidence and its discriminatory nature.11 The WCHP overemphasises the role of weight in health outcomes, falsely assumes that weight-loss treatments are effective, sustainable, and non-harmful, perpetuating weight stigma. The Clinical Guidelines for Weight Management in New Zealand Adults (Ministry of Health 2017) reflect the WCHP and are outdated and harmful.12 Achieving and maintaining weight loss is extraordinarily difficult. Research using primary care data from the UK found the probability of a person with obesity attaining and maintaining normal weight for 9 years was 1/1290 for men and 1/677 for women.13 BMI is still used to limit access to clinical services, in ways that differentially affect already disadvantaged groups.

Finding a doctor who wants to treat me as a patient without prerequisite weight loss has been nearly impossible throughout my life.14

Eligibility and equity

Many elective surgical and assisted reproductive procedures in NZ are restricted to patients whose weight is below a certain BMI, and patients are often encouraged to rapidly lose weight to access services, despite the risks of weight cycling and weight regain. Given the
demonstrated difficulty in losing weight, BMI cut-offs amount to absolute barriers, preventing some patients from accessing beneficial cost-effective clinical interventions. For example, obesity is linked to anovulation and subfertility, and therefore women with a BMI ≥30 kg/m² are more likely to require assisted reproductive technologies (ARTs). Obesity is linked to an increased risk of pregnancy complications such as hypertensive disorders, gestational diabetes and caesarean section. However, recent high-quality clinical research (including RCTs (randomised controlled trials)) shows that intensive weight reduction programs prior to in vitro fertilisation (IVF) do not increase live birth rates for infertile women with obesity. There is limited data regarding the impact of pre-surgical weight loss interventions on clinical outcome (excluding bariatric surgery). A recent systematic review of the evidence is low quality and found that weight loss diets before elective surgery do not reduce postoperative complications. BMI cut-offs disproportionately impact Māori and Pacific patients, thereby contributing to ongoing health disparities and systemic inequalities. Therefore, BMI cut-offs also conflict with the Equity Adjustor Score (EAS) recently announced by Te Whatu Ora. The EAS aims to prioritise access to surgery for Māori, Pacific and rural patients; but this equity initiative risks being nullified by BMI cut-offs.

Stigma, discrimination and bias

The so called ‘War on Obesity’ fuels harmful weight stigma, discrimination, and anti-fat bias in medicine. Fatphobia has been defined as ‘the implicit and explicit bias of overweight individuals that is rooted in a sense of blame and presumed moral failing.’ It is well documented that patients with high body mass experience negative attitudes and disrespectful treatment from health professionals, with attribution of presenting health issues to excess weight and assumptions about weight gain as well as barriers to healthcare utilisation. Experience of weight stigma itself causes psychological and physical harm, leads to weight gain and is a barrier to timely and effective medical care. Both explicit and implicit fatphobia is pervasive in medical culture, and international research shows that doctors are one of the most frequent sources of weight bias experienced by fat people. Recent research with NZ dietitians shows negative implicit weight bias in their clinical management of patients. Fatphobia in medicine is difficult for health providers to navigate, and there is limited support or training. General practitioners (GPs) in NZ experience disempowerment regarding their ability to ‘treat’ obesity in their patients. Doctors and nurses in NZ experience social awkwardness caring for patients with obesity in the intensive care unit (ICU). There is no empirical evidence of the extent or self-awareness of anti-fat bias among health providers in Aotearoa NZ. Health providers must not contribute to psychosocial pressure on patients to lose weight in order to conform to body image norms; providers should recommend evidence-based strategies to improve wellbeing and health – this means focusing on enhancing mana, diet, exercise, and social connectedness.

To weigh or not to weigh?

A belief in the advantage of weight loss is pervasive. Claims that weight counselling is effective frequently rest on studies that show short-term weight loss, rather than evidence of long-term weight maintenance or changes in meaningful clinical outcomes.

I saw six doctors. I was told it’s in my head. My personal favorite from when I told a doctor I was vomiting daily: ‘That’s a good thing, you need to lose weight.’ The sixth doctor listened. He found the culprit: adenomyosis.

Weight bias is associated with racism, as an ostensibly biological basis for validating race, class, and gender stereotypes and prejudice. Māori and Pacific people with obesity are at increased risk of being stigmatised as ‘diseased’ because contemporary ideals of thinness are racialised and racist, contributing to systemic racism in health systems. As our health system works to acknowledge and mitigate the history of colonisation and systemic racism, it is essential to combat anti-fat bias in medicine and disentangle the clinical evidence for BMI cuts-offs from generalised fatphobia.

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<th>Do weight interventions cause harm?</th>
<th>Experience of weight stigma</th>
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<td>- Decreased self-regulation</td>
<td>- Increased cortisol</td>
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<td>- Increased eating</td>
<td>- Increased eating</td>
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<td>- Internalised shame and avoidance of exercise</td>
<td>- Avoidance or delay seeking health care</td>
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<td>- High weight self-stigma and lower quality of life</td>
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Routine uncritical adoption of weight loss promotion in primary care harms patients, undermines trust in the provider–patient relationship, and presents only small, if any, changes to improving patient health. Prompting lifestyle interventions to promote weight loss is not safe, effective, or ethical care for patients with a high BMI. Health providers must grapple with the role fatphobia in medicine has and does play in harming patients, creating barriers to health care, and mis-, under- and delayed diagnosis of health conditions for fat patients. Primary care should shift towards a weight-neutral paradigm, which promotes and facilitates health, mana, and wellbeing at any size.

References

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