CSIRO PUBLISHING
The Royal New Zealand College of General Practitioners
Te Whare Tohu Rata o Aotearoa
BACK TO BACK
https://doi.org/10.1071/HC23163
Journal of Primary Health Care

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,*]

For full list of author affiliations and declarations see end of paper

***Correspondence to:**
Lesley Gray
Department of Primary Health Care & General Practice, University of Otago, Wellington/Te Whare Wānanga o Otāgo ki Te Whanga-Nui-a-Tara, 6242, New Zealand/Aotearoa
Email: lesley.gray@otago.ac.nz

Received: 1 December 2023
Accepted: 1 December 2023
Published: 18 December 2023

Cite this:
Ballantyne A *et al.*
Journal of Primary Health Care 2023; **15**(4): 385–387.
doi:10.1071/HC23163

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) $>30\,kg/m^2$ (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 $25\,kg/m^2$ and above range is associated with significantly lower mortality compared to BMI in the 18–$25\,kg/m^2$ 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 BMI[9] – 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 patients 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

While evidence can help inform best practice, it needs to be placed in context. There may be no evidence available or applicable for a specific patient with his or her own set of conditions, capabilities, beliefs, expectations and social circumstances. There are areas of uncertainty, ethics and aspects of care for which there is no one right answer. General practice is an art as well as a science. Quality of care also lies with the nature of the clinical relationship, with communication and with truly informed decision-making. The **BACK TO BACK** section stimulates debate, with professionals presenting their opposing views regarding a clinical, ethical or political issue.

demonstrated difficulty in losing weight,[13] 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,[15] and therefore women with a BMI $\geq 30\,kg/m^2$ 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.[16–18] 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.[19] 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.[20] The ESA 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.[21] 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.'[22] It is well documented that patients with high body mass experience negative attitudes and disrespectful treatment from health professionals,[23] with attribution of presenting health issues to excess weight and assumptions about weight gain as well as barriers to healthcare utilisation.[24] Experience of weight stigma itself causes psychological and physical harm, leads to weight gain and is a barrier to timely and effective medical care.[25–28] Both explicit and implicit fatphobia is pervasive in medical culture,[29] and international research shows that doctors are one of the most frequent sources of weight bias experienced by fat people.[30] Recent research with NZ dietitians shows negative implicit weight bias in their clinical management of patients.[31] 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.[32] Doctors and nurses in NZ experience social awkwardness caring for patients with obesity in the intensive care unit (ICU).[33] 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.[34] Claims that weight counselling is effective frequently rest on studies that show short-term weight loss,[35] 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. [36]

Weight bias is associated with racism, as an ostensibly biological basis for validating race, class, and gender stereotypes and prejudice.[37] 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.[37] 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.

Do weight interventions cause harm?	**Experience of weight stigma**
	• Decreased self-regulation
	• Increased cortisol
	• Increased eating
	• Internalised shame and avoidance of exercise
	• Avoidance or delay seeking health care
	• High weight self-stigma and lower quality of life

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 patient-centred. Aotearoa NZ needs new research-informed policy to address weight-linked inequities and educational resources for health providers to support safe, effective, and 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

1 NCD Risk Factor Collaboration (NCD-RisC). Worldwide trends in body-mass index, underweight, overweight, and obesity from 1975 to 2016: a pooled analysis of 2416 population-based measurement studies in 128.9 million children, adolescents, and adults. *Lancet* 2017; 390(10113): 2627–42. doi:10.1016/S0140-6736(17)32129-3
2 Ministry of Health. Annual Data Explorer 2020/21: New Zealand Health Survey [Data File]; 2021. Available at https://minhealthnz.shinyapps.io/nz-health-survey-2020-21-annual-data-explorer/

3 Puhl RM, Heuer CA. Obesity stigma: important considerations for public health. *Am J Public Health* 2010; 100(6): 1019–28. doi:10.2105/AJPH.2009.159491
4 Wiebe N, Lloyd A, Crumley ET, *et al.* Associations between body mass index and all-cause mortality: a systematic review and meta-analysis. *Obes Rev* 2023; 24(10): e13588. doi:10.1111/obr.13588
5 Moharram MA, Aitken-Buck HM, Reijers R, *et al.* Correlation between epicardial adipose tissue and body mass index in New Zealand ethnic populations. *N Z Med J* 2020; 133(1516): 22–32.
6 Tomiyama AJ, Hunger JM, Nguyen-Cuu J, *et al.* Misclassification of cardiometabolic health when using body mass index categories in NHANES 2005-2012. *Int J Obes* 2016; 40(5): 883–6. doi:10.1038/ijo.2016.17
7 Nutter S, Eggerichs LA, Nagpal TS, *et al.* Changing the global obesity narrative to recognize and reduce weight stigma: a position statement from the World Obesity Federation. *Obes Rev* 2023; e13642. doi:10.1111/obr.13642
8 World Health Organization. Social determinants of health. World Health Organization, Geneva; 2023. Available at https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1
9 Matheson EM, King DE, Everett CJ. Healthy lifestyle habits and mortality in overweight and obese individuals. *J Am Board Fam Med* 2012; 25(1): 9–15. doi:10.3122/jabfm.2012.01.110164
10 Tylka TL, Annunziato RA, Burgard D, *et al.* The weight-inclusive versus weight-normative approach to health: evaluating the evidence for prioritizing well-being over weight loss. *J Obes* 2014; 2014: 983495. doi:10.1155/2014/983495
11 Bacon L, Aphramor L. Weight science: evaluating the evidence for a paradigm shift. *Nutr J* 2011; 10(1): 9. doi:10.1186/1475-2891-10-9
12 Ministry of Health. Clinical Guidelines for Weight Management in New Zealand Adults, 2017. Wellington: Ministry of Health.
13 Fildes A, Charlton J, Rudisill C, *et al.* Probability of an obese person attaining normal body weight: cohort study using electronic health records. *Am J Public Health* 2015; 105: e54–9. doi:10.2105/AJPH.2015.302773
14 Enneking C. In K. Cloyd, Fat Women are Tired of Being Treated Poorly By Doctors. *Scary Mommy*, 8 November 2019. Available at https://www.scarymommy.com/doctors-stop-dismissing-fat-people
15 Silvestris E, de Pergola G, Rosania R, *et al.* Obesity as disruptor of the female fertility. *Reprod Biol Endocrinol* 2018; 16: 22. doi:10.1186/s12958-018-0336-z
16 Einarsson S, Bergh C, Friberg B, *et al.* Weight reduction intervention for obese infertile women prior to IVF: a randomized controlled trial. *Hum Reprod* 2017; 32(8): 1621–30. doi:10.1093/humrep/dex235
17 Wang Z, Groen H, Van Zomeren KC, *et al.* Lifestyle intervention prior to IVF does not improve embryo utilization rate and cumulative live birth rate in women with obesity: a nested cohort study. *Hum Reprod Open* 2021; 2021(4): hoab032. doi:10.1093/hropen/hoab032
18 Legro RS, Hansen KR, Diamond MP, *et al.* Effects of preconception lifestyle intervention in infertile women with obesity: the FIT-PLESE randomized controlled trial. *PLoS Med* 2022; 19(1): e1003883. doi:10.1371/journal.pmed.1003883
19 Pavlovic N, Boland RA, Brady B, *et al.* Effect of weight-loss diets prior to elective surgery on postoperative outcomes in obesity: a systematic review and meta-analysis. *Clin Obes* 2021; 11(6): e12485. doi:10.1111/cob.12485
20 Soper B, Walls J. Auckland surgeons must now consider ethnicity in prioritising patients for operations – some are not happy. *New Zealand Herald*, 19 June 2023. Available at www.nzherald.co.nz/nz/auckland-surgeons-must-now-consider-ethnicity-in-prioritising-patients-for-operations-some-are-not-happy/ONGOC263IFCF3LADSRR6VTGQWE/
21 O'hara L, Gregg J. The war on obesity: a social determinant of health. *Health Promot J Austr* 2006; 17(3): 260–3. doi:10.1071/he06260
22 Boston Medical Center. Fatphobia. 2013. Available at https://www.bmc.org/glossary-culture-transformation/fatphobia
23 Gudzune KA, Beach MC, Roter DL, *et al.* Physicians build less rapport with obese patients. *Obesity* 2013; 21(10): 2146–52. doi:10.1002/oby.20384
24 Alberga AS, Edache IY, Forhan M, *et al.* Weight bias and health care utilization: a scoping review. *Prim Health Care Res Dev* 2019; 20: E116. doi:10.1017/S1463423619000227
25 Remmert JE, Convertino AD, Roberts SR, *et al.* Stigmatizing weight experiences in health care: associations with BMI and eating behaviours. *Obes Sci Pract* 2019; 5(6): 555–63. doi:10.1002/osp4.379
26 Mensinger JL, Tylka TL, Calamari ME. Mechanisms underlying weight status and healthcare avoidance in women: a study of weight stigma, body-related shame and guilt, and healthcare stress. *Body Image* 2018; 25: 139–47. doi:10.1016/j.bodyim.2018.03.001
27 Guardabassi V, Mirisola A, Tomasetto C. How is weight stigma related to children's health-related quality of life? A model comparison approach. *Qual Life Res* 2018; 27: 173–83. doi:10.1007/s11136-017-1701-7
28 Khodari BH, Shami MO, Shajry RM, *et al.* The relationship between weight self-stigma and quality of life among youth in the Jazan Region, Saudi Arabia. *Cureus* 2021; 13(9): e18158. doi:10.7759/cureus.18158
29 Phelan SM, Burgess DJ, Yeazel MW, *et al.* Impact of weight bias and stigma on quality of care and outcomes for patients with obesity. *Obes Rev* 2015; 16(4): 319–26. doi:10.1111/obr.12266
30 Puhl RM, Brownell KD. Confronting and coping with weight stigma: an investigation of overweight and obese adults. *Obesity* 2006; 14(10): 1802–15. doi:10.1038/oby.2006.208
31 Roy R, Kaufononga A, Yovich F, *et al.* The prevalence and practice impact of weight bias among New Zealand registered dietitians. *Nutr Diet* 2023; 80(3): 297–306. doi:10.1111/1747-0080.12791
32 Claridge R, Gray L, Stubbe M, *et al.* General practitioner opinion of weight management interventions in New Zealand. *J Prim Health Care* 2014; 6(3): 212–20. doi:10.1071/HC14212
33 Hales C, de Vries K, Coombs M. Managing social awkwardness when caring for morbidly obese patients in intensive care: a focused ethnography. *Int J Nurs Stud* 2016; 58: 82–9. doi:10.1016/j.ijnurstu.2016.03.016
34 Hagan S, Nelson K. Are current guidelines perpetuating weight stigma? A weight-skeptical approach to the care of patients with obesity. *J Gen Intern Med* 2023; 38: 793–8. doi:10.1007/s11606-022-07821-w
35 Hall KD, Kahan S. Maintenance of Lost Weight and Long-Term Management of Obesity. *Med Clin North Am* 2018; 102(1): 183–197. doi:10.1016/j.mcna.2017.08.012
36 Amanda. It's not all in our heads: women speak out about feeling dismissed by doctors. *Today*, 2023. Available at https://www.today.com/health/women-speak-out-about-feeling-dismissed-doctors-t153701
37 Strings S. Fearing the black body: the racial origins of fat phobia. New York: New York University Press; 2019.

Data availability. No data were used to generate results, other than referenced sources.

Conflicts of interest. The authors declare no conflicts of interest.

Declaration of funding. This research did not receive any specific funding.

Author affiliations

[A]University of Otago, Wellington, New Zealand.

[B]Department of Primary Health Care & General Practice, University of Otago, Wellington/Te Whare Wānanga o Otāgo ki Te Whanga-Nui-a-Tara, 6242, New Zealand/Aotearoa.

[C]Department of Psychological Medicine, University of Otago, Wellington, Te Whare Wānanga o Otāgo ki Te Whanga-Nui-a-Tara, Wellington 6242, New Zealand/Aotearoa.