The Weighty Burden of Inequity Experienced by Patients in Larger Bodies: Fostering Equitable Treatment in the Naturopathic Community

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Abstract:

Individuals identified as overweight or obese (people in larger bodies) often endure poor health equity as a result of pervasive stigmatization and discrimination due to their weight, in both social and healthcare settings. Often referred to as 'weight bias', people in larger bodies are differentially, and inequitably, treated specifically due to their weight. This inequitable treatment results in deleterious health effects, such as poorer mental health, increased risk of mortality, avoidance to seek care, social isolation, and disadvantageous physiologic changes (e.g. elevated C-reactive protein). In an effort to foster equitable, inclusive, and fair treatment of all patient groups accessing naturopathic care, this critical reflection and narrative literature review was undertaken in order to explore important considerations specifically for people in larger bodies. Further, it may serve as a guide for naturopathic doctors (NDs) to appreciate the sensitivity of terminology, the complexity of weight-related research, the caution that must be taken with social media use and the unintentional, but likely, harms of hyperfocusing on weight. A call for actionable changes is relayed in order to provide the ND community with tangible and achievable goals to consciously work towards in order to foster equitable care and treatment of all patients, regardless of body size.

Introduction

People identified as obese or overweight, hereinafter equitably referred to as 'people in larger bodies', face pervasive stigmatization due to their weight, jeopardizing their mental and physical health.[1] As a result of weight bias, this group experiences negative peer attitudes, blame, worsening psychological health, and poorer healthcare quality. These observations signal both a social justice and public health issue.[1]

Discrimination experienced by people in larger bodies is a pervasive issue in healthcare. A 2019 scoping review (21 studies) of weight bias and healthcare utilization, identified 10 prominent themes among larger bodied people, including 'disrespectful treatment', 'attribution of all health issues to excess weight', 'low trust and poor communication', 'avoidance/delay of health services' and 'ambivalence'.[2] Weight discrimination, *regardless* of an individual's weight, is associated with poorer mental health, increased food intake, exercise avoidance, weight gain, heightened long-term cardio-metabolic risks and increased risk of mortality.[3] Physicians spend less time during appointments and provide less education to individuals in larger bodies compared to their thinner counterparts.[3] Furthermore, it results in avoidance of future care, poorer treatment outcomes, compromised cancer screening participation, and deficits in health insurance coverage.[3] During the COVID-19 pandemic, weight bias is implicated in the reluctance to seek necessary medical care,[4] exacerbation of associated inequities (e.g. racism.),[4] intensification of weight discrimination in social media (e.g. 'quarantine 15'),[5] and psychological distress (e.g. stress caused by disproportionate media coverage/focus on obesity and COVID-19 outcomes).[6]

In the interest of providing equitable naturopathic care, it is imperative that naturopathic doctors (NDs) are mindful of non-discriminatory approaches to treatment. This critical reflection/narrative review will explore important considerations for the equitable, inclusive, and fair treatment of people in larger bodies. A narrative review methodology was implemented, accessing initially systematic synthesis work, followed by the application of a branching search approach to identify additional relevant literature, without systematic searching, which is beyond the scope and intent of this reflection.

I. Concepts & Terminology

Language that is accurate and non-discriminatory is essential for achieving health equity. Below, relevant terms are defined and explored. Language is constantly evolving, and words gain new meaning, often reclaimed over time by the marginalized groups that were affected by them. As language is shaped by humankind, real-life examples were accessed where applicable to capture current anthropological uses of certain words by the users themselves (people in larger bodies).

Obese

Obesity is often defined as a body mass index (BMI) above 30.[7] The term 'obesity' has been widely used in the medical and research community.[1]

BMI

Calculated by dividing weight (in kilograms) by square of height (meters).[8] Intended to be used for weight category screening but is not diagnostic of adiposity or indicative of health status.[7] First developed in the 1800's by Adolphe Quetelet (termed the Quetelet Index until 1972 when Ancel Keys renamed it), who was an astronomer, mathematician and sociologist[9]. BMI accuracy is limited according to the totality of research, and is often a poor predictor of diagnosing obesity, especially in non-white populations.[10-12]

Fat

A descriptor being reclaimed by the body-positive community, specifically those members who are in larger bodies. Fat is intended as a neutral descriptor but is still used in negative/harmful ways by straight-sized people and medical professionals.[1]

Straight-size

Individuals who are not at risk of discrimination due to weight.[13] This word is used instead of 'thin' because not everyone identifies with being thin. This word is used instead of 'average' because the average size in Canada is not 'straight size', and would be considered 'overweight.'[13,14]

Individual in a larger body

This term is intended to be neutral.[15] Like many terms used to describe oppressed groups of individuals, it is imperfect. Some individuals feel that this phrase is still offensive, some feel that it makes them sounds like they are a thin person 'trapped' in a larger body, and some value the attempt at political correctness but find it overly wordy.

Fatphobia

Previously defined as 'fear of fatness' within the context of disordered eating or body dysmorphia. However, the word has evolved to describe discrimination against people in larger bodies. This includes paying larger people less money, providing less comprehensive medical care, charging additional fees on an airplane.[16]

II. Research Concepts & Considerations

Health Consequences of weight-specific discrimination

Weight specific discrimination *in and of itself* is associated with poorer outcomes. The *Health and Retirement Study* (HRS) (n=13,692) and the *Midlife in the United States Study* (MIDUS) (n=5079) indicate that weight discrimination itself is associated with an almost 60% increased risk of mortality, not attributable to physical and psychological factors; HR: 1.57; 95% CI: 1.34 - 1.84 (HRS) and HR: 1.59; 95% CI: 1.09-2.31 (MIDUS).[17] Weight stigma is also associated with impaired ability to make healthful changes. Stigmatizing someone about their weight can trigger unhealthy eating patterns (e.g. skipping meals), binge eating, *increased* food intake, and reduced motivation to adopt 'healthier' dietary behaviors.[18] Weight stigma has also been associated with physiological changes, such as elevated levels of cortisol, oxidative stress, and C-reactive protein.[19] Qualitative research has also described the negative effects of weight stigma. Patients enrolled in a commercial weight management program (n=425) who were still feeling distressed from prior weight stigmatizing events (58%) reported that 1) it shaped their self-perception, 2) they blamed themselves for the consequences of weight bias and 3) they often ruminated on memories of weight discrimination.[20] Stories from people in larger bodies from narrative inquiry reveal that their behavior, such as health promoting action avoidance and social isolation, are common responses to weight discrimination.[21] Taken all together, inequitable treatment due to pervasive, yet avoidable, weight discrimination causes people in larger bodies to experience poorer overall health. NDs should be aware that weight discrimination experiences are likely affecting the health and overall wellbeing of their patients in larger bodies.

Social determinants of health

External societal and environmental factors greatly determine one's health, particularly the social determinants of health (SDOH). Obesity can be considered as a possible sequela of inequity (e.g., poverty), which requires social intervention, not weight loss.

Socioeconomic status (SES) is a strong determinant of health for a multitude of endpoints, including obesity. A 2019 meta-analysis of 21 observational studies (n= 1,233,438) found that low neighborhood SES increased the odds of being overweight by 31% (OR: 1.31; 95% CI: 1.16-1.47, p<0.0001) and the odds of being obese by 45% (OR: 1.45; 95% CI: 1.21-1.74, p<0.001).[22]

Racism has also been observed to increase the risk of obesity. An important equity study, the *Black Women's Health Study*, found that those in the highest category of experienced every day or lifetime racism had a significantly increased risk of obesity, compared to those in the lowest category, in both 1997 (1.69; 95% CI: 1.45-1.96, p<0.01) and 2009 (1.38; 95% CI: 1.15-1.66, p<0.01).[23] We conjecture that additional weight discrimination would only worsen this health equity discrepancy.

Non-heterosexual individuals face pervasive inequitable treatment,

increasing the risk of certain health related outcomes. A study accessing data from the *Behavioral Risk Factor Surveillance System* (BRFSS) surveys (n=716,609) found that compared to straight adults, women who identified as lesbian had a significantly higher odds of being overweight (OR: 1.33; 95% CI: 1.17-1.53), as well as being obese (OR: 1.49; 95% CI: 1.31-1.70). Bisexual women, compared to straight adults, also had significantly higher odds of being overweight (OR: 1.21; 95% CI: 1.10-1.34) and obese (OR: 1.43; 95% CI: 1.29-1.59).[24] Interestingly, this association did not exist for men identifying as either gay or bisexual when compared to straight counterparts.[24]

Patterns of Association Between Weight and Health Outcomes

U-shaped associations and confounding variables are two important, and complementary, concepts in weight-related research that are essential for deciphering the association between obesity and health outcomes.

The association between weight and health outcomes are generally observed to be 'U-Shaped', with negative effects primarily occurring at the two extremes (underweight and very overweight), with null effects observed in the middle ('normal' weight to slightly overweight).[25] This association is consistently observed between BMI and mortality.[26] A cohort study (n= 346,500) spanning 56 years, observed that the association between mortality and BMI was steady over the study period, with only those at the two extremes experiencing an increased risk.[27] This U-shape association is also found for diseased patient groups, where a meta-analysis of 14 prospective cohort studies (n= 46,794) found that people with heart failure with a slightly higher BMI (> 28 kg/m2) had better survival, whereas those who were underweight or severely overweight (BMI > 37 kg/m2) faired worse.[28] This U-shaped weight/BMI association has also been observed for all-cause mortality in patients with diabetes,[29] risk of depression,[30] prevalence of dysmenorrhea,[31] and all-cause mortality and disability among the elderly.[32]

The importance of metabolic abnormalities rather than BMI

The presence of comorbidities can result in meaningful confounding, rendering BMI status alone to be a poor predictor of current health, future risk/adverse events and who would benefit from weight los.[33] In general, the risk of type II diabetes, cardiovascular disease and all-cause mortality is more so influenced by the number and severity of metabolic abnormalities present (e.g. insulin resistance), rather than the isolated occurrence of obesity alone.[33] It is also notable that health improvements occur *in the absence of weight loss*, with a Cochrane review on exercise and type II diabetes indicating that physical activity improved glycemic control, reduced visceral adipose tissue, and triglycerides, *even without weight loss.*[34] Encouraging exercise for improving health rather than for weight loss, both addresses important disease endpoints while avoiding the chance of stigmatizing a patient about their weight. Furthermore, there is evidence of an absence of benefit for weight loss for people in larger bodies who are otherwise healthy (absence of comorbidities). A meta-analysis of 26 prospective studies tracking mortality after weight loss by means of lifestyle found that the evidence does not support advising people who are overweight or obese, who are otherwise healthy, to lose weight to reduce mortality (no benefit).[35]

TAKEAWAYS:

1. Be mindful of the negative impact of weight specific discrimination and the possible unconscious ways you may be engaging in it
2. Always consider and explore SDOH associated with weight status
3. Understand that the association between weight and health outcomes is complex, with thresholds existing at both ends for negative outcomes
4. Communicate to your patients that 'thinner' does not equal healthier, and often the opposite is true, especially when comorbidities are unaddressed/absent.

III. Social Media Marketing & Messaging

Social media (SM) accounts, especially those that promote 'health', are associated with worsening body image, disordered health behaviours (e.g. strict dieting), and health focused disordered eating/obsessions ('orthorexia nervosa').[36] An identified culprit for this association is 'SM influencers' who perpetuate unrealistic body types and suggest that weight is entirely in the control of the individual.[37,38]

Evidence suggests that up to 90% of medical doctors use SM for personal use and 65% use it for professional activities such as communicating with patients.[39] With more health care providers using SM for professional purposes, additional ethical questions arise around boundaries, confidentiality, informed consent, duty of care, privacy, and patient over-dependence.[40]

It is publicly observed that NDs use SM to market to a broad audience. While it is beyond the scope of this review to describe/quantify the current online behavior of NDs, like any healthcare profession, the naturopathic community is vulnerable to weight bias. As it is ineffective to only respond to health inequities only once they have been formally described, to both address current issues and prevent future propagation of oppression, we will present hypothetical examples for consideration. This will allow 1) NDs who are unknowingly using stigmatizing messaging to reflect and improve and 2) aid those looking to use SM in the future to make equitable decisions.

IV. The Responsibility of the ND Community

It is the responsibility of the ND community to consider their choice of words and actions — in person and online — and the effects it has on the person on the receiving end. Health is not binary. To '*do no harm*' we must remember that a person's health, including their weight, is shaped by a multitude of dynamic factors. We identify that a person's weight, on both extremes, can impact their health.

POSSIBLE PROBLEMATIC MESSAGES & EQUITABLE ALTERNATIVES

Example	Concern	Suggestion
"The true pandemic is obesity"	Minimizes the severity of the COVID-19 pandemic. Promotes victim blaming and weight shaming/vilification.	Discuss risk factors through a lens that empowers individuals to change modifiable ones. Avoid using the term "pandemic" to describe obesity prevalence which vilifies patients.
"Most people who have died from COVID-19 were overweight or had another major health concern"	Weight loss is not a short-term solution. This comment is mostly to comfort straight-sized people.	Acknowledge the many confounding variables and consider weight as more of a by-product of negative health exposures (poverty, food insecurity, racism, experienced discrimination, insulin resistance, etc.).
"War on obesity"	This term may be interpreted as a war on obese individuals. This phrase ultimately marginalizes larger individuals and may cause shame and feelings of failure if unable to lose weight.	Focus on the concerning health outcomes. Avoid using the phrase "war on…" when discussing individuals that belong to any group.
"Weight doesn't matter as long as you are healthy"	Promotes the idea that only healthy people/bodies are valid, which is both ableism and healthism.	Tie the health outcomes to the patient's goals. If they don't have metabolic goals this isn't relevant dialogue.
"Losing weight is part of treating the root cause…"	Weight is rarely the root cause of an illness. Because weight loss is a slow process, suggesting it as a treatment leaves people to deal with symptoms for extended time periods (if they end up losing weight at all). Focusing on weight removes focus from other, treatable causes of illnesses.	Consider how you would discuss a certain illness if a thin individual suffered from it. For example, knee pain may improve if a larger individual lost weight but that individual also deserves imaging, physiotherapy, anti-inflammatory supplements, etc.
"Your weight may be holding you back from living your best life"	Most people are aware of the size of their body and do not benefit from someone informing them that they are overweight/obese. This may make larger individuals feel unwelcome in naturopathic offices if weight loss is not one of their health goals. It implies that someone cannot have a "best life" if they are overweight, making weight a focus of their entire capacity to live and exist.	Focus on specific health goals and how to support those health goals in the short and long term.
Toxic body positivity: "Just need to love their bodies".	These messages blame the individuals for the oppression/discrimination they experience from society as a whole and suggests that their problems would be solved if they simply loved themselves.	Empower individuals through education to be their own health advocates. Identify yourself as someone who promotes healthy lifestyle changes without the goal of weight loss and works with individuals of all sizes.
Fear-based marketing	Fear-based marketing messages do not promote or encourage long-term health behaviours.	Place the emphasis on health-promoting behaviours. Instead of, "Being overweight or obese is a risk factor for diabetes. Book an appointment to address your weight and prevent diabetes", try "Lifestyle factors can play a role in your risk of diabetes. Book an appointment today to learn how you can adopt healthy habits". When they are in your office, you can discuss options such as a healthy diet, regular exercise, and supplements to mitigate their risk.

However, it is the responsibility of the ND community to consider their choice of words and actions - in person and online - and the effects it has on the person on the receiving end. To reiterate a point made earlier, regardless of a patient's weight they deserve rigorous assessment and compassionate care. Something to reflect on the next time this comes up in practice: Is the intent of my message or recommendation thinness or health?

Conclusion:

By acknowledging the detrimental effects of weight bias, stigmatization and discrimination, the naturopathic community can take conscious measures to both correct current unequitable behavior and prevent future unintentional harm. The intent of this review was not to vilify any individual ND nor to undervalue the care provided, but rather to remind us all that our patients often seek our care in hopes of a safe environment to explore their health/wellbeing, which can be undermined by weight bias and stigmatization. To achieve equitable care, we must interpret research judiciously, acknowledge the very real harms of weight bias, adapt terminology and messaging, and ensure that we foster a professional community void of fatphobia if our intent is to truly help people, and not weigh them down further.

CALL FOR ACTIONABLE CHANGE:

We call on all NDs to...

1. Consider whether discussing weight provides meaningful benefit to the patient that outweighs the known harms of discrimination.
2. Assess whether the goal of their recommendation is thinness or health.
3. Ensure marketing is inclusive, while keeping in mind important SDOH.
4. Avoid fear-based marketing strategies around weight or statistics suggesting weight is a single causative factor to any health outcome. Avoid absolutist ideas that weight loss "solves" health concerns.
5. Utilize equitable terminology based on available literature and input from those with lived experience. When in doubt, ask the individual what terminology they prefer.
6. Honour larger bodies and remove the goal of "fixing" them, while still supporting the patient's health goals.

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