

# Virtual Mentor

American Medical Association Journal of Ethics  
April 2010, Volume 12, Number 4: 258-262.

## CLINICAL CASE

### Weight-Based Stigma and Physician Bias

Commentary by Lawrence J. Cheskin, MD, Scott Kahan, MD, MPH, and Gail Geller, ScD, MHS

Mrs. Williams visited her primary care physician, Dr. Smith, for a hospital follow-up (2 days after discharge) and evaluation of type 2 diabetes mellitus, hypertension, and hypercholesterolemia. She was obese (BMI of 50) and had been hospitalized for acute renal failure due to dehydration, respiratory distress, and poor-healing chronic decubitus ulcers. Her family believed the medical staff was to blame for Mrs. Williams' current medical problems. They stated that she was receiving "inappropriate care" and that the physicians involved in treatment were "just putting a band-aid on her and trying to discharge her as quickly as possible" during each admission. This hospitalization marked her 10th in the last 5 months for similar symptoms.

During her last hospitalization, the medical team had spoken with Mrs. Williams about her weight's being the primary confounding factor in treatment of her other medical conditions. Dr. Smith asked, "Mrs. Williams, do you understand how your weight has complicated the care that we are able to provide? We are just treating these acute flare-ups until we can address the fact that each of them will improve with weight loss." She replied, "I'm tired of you doctors telling me I'm fat. I know that, but I think that you're using it as an excuse not to try hard enough to address my other issues. I've seen how you look at me. I just wish someone would treat me like a human being."

Mrs. Williams has changed her primary care physician several times over the last few years because of "maltreatment" and "disrespect" by her physicians. She believes that as she has gained weight over the years, she has been treated more poorly by her physicians. She has been on a quest to find a physician who will treat her as he or she would treat a thinner patient, but each physician that she has seen has focused on her morbid obesity as a primary cause of her current diagnoses. While all of them have given her information on dietary changes and physical activity recommendations, she has not heeded their advice, due in part to their abrasive approach.

### Commentary

Mrs. Williams' case highlights the difficulties we may face as well-intentioned caregivers in communicating and, indeed, empathizing and connecting with some of our patients who are very obese. As with many problematic areas we face as clinicians, the challenge may stem from our own biases.

It is well documented that health professionals often carry the negative biases of our society toward individuals who are obese [1-3]. Cultivating an awareness of our own biases is the best way to avoid acting on them. Self-awareness, however, is difficult when these biases are unconscious. In *The Silent World of Doctor and Patient*, psychiatrist Jay Katz, one of the fathers of American bioethics, highlights the ways in which unquestioned professional attitudes can interfere with the development of a trusting and respectful relationship with patients [4]. According to Katz, “these attitudes include the need to appear authoritative, the importance of hiding uncertainties from patients, the need to view patients as incompetent to participate in decision-making, and the belief that patients’ welfare depends on patients’ trusting doctors’ capacities to know what is in patients’ best interests” [4].

When caring for patients whose obesity or other disease requires significant and often difficult lifestyle changes, doctors may not know or may disagree with patients’ perceptions of what is in their best interests or may feel inadequate to help their patients achieve medical goals. It is important for doctors to reflect on their own feelings of hopelessness and helplessness to make a difference in their patients’ lives, as well as their personal or familial experiences or challenges with weight management, in order to overcome the impediments to a trusting and respectful relationship with their patients.

Problems with patients like Mrs. Williams may also arise because of our failure to fully grasp the situation, the patient’s “issues,” or both. What appears to be occurring in Mrs. Williams’ case is common among patients, obese or not; i.e., when things are not going well in treatment, the patient and family members tend to become progressively disenchanted with the care and the caregivers, especially the “lead” caregivers, the medical staff. Our reaction to this is also a commonly experienced one: as humans who believe we generally do our best for people under our care, we will listen to the criticism and attempt to evaluate it objectively but, after doing this, typically reject the “blame” and pass some of it back to the patient.

Mrs. Williams provides grist for this reaction, since she has an obvious risk factor—her extreme obesity—and has not responded to advice to lose weight. It is important for her caregivers to step back from their emotional reaction to her criticism and her lack of response to their well-meaning advice and decide whether they can examine their own motivations and feelings of inadequacy, put themselves in the patient’s shoes, and do a better job partnering with her in this effort.

It is unfortunate but true that the amount of time spent on nutrition and exercise teaching during medical school and residency is paltry compared to the important role these factors play in determining both medical risks and outcomes. In fact, it has been noted that physicians usually report feeling inadequately trained to help patients lose weight, yet seldom refer such patients to other professionals for that purpose [5]. Thus, it is likely that the dietary and exercise advice offered to Mrs. Williams was ineffectively general (e.g., “just eat less, exercise more”), and based on unwarranted

and possibly derogatory assumptions about her habits (e.g., “just stop eating junk food”), knowledge (e.g., “try the South Beach diet”), means (e.g., “join a health club”), or abilities (e.g., “start jogging a couple of miles a day”). Moreover, physicians are not always skilled at assessing their patients’ motivation to lose weight [6].

Patient motivation for making difficult behavioral changes in the face of our “obesigenic” society is a complex phenomenon that requires sensitivity, flexibility, and persistence on the part of the clinician to effectively manage. An oft-observed phenomenon is the limited power of health improvements to serve as motivators for weight change. The potency of small improvements can be increased by emphasizing more subjective measures, such as how the patient feels after weight loss (e.g., more energy, reduced fatigue, greater mobility and ability to enjoy life) rather than focusing on the number-driven medical criteria that we tend to use (e.g, blood pressure, cholesterol, cardiac risk). Establishing initially modest expectations, providing consistent feedback, monitoring adherence, and offering constructive encouragement are elements of successful weight loss, both short-term and in the long run.

Not establishing accountability is the kiss of death to reaching goals. There is a risk, of course, that holding some individuals accountable for nonadherence to mutually established goals will cause resentment or result in their dropping out of treatment. It is in such cases that one’s skill in the art of medicine is most sorely tested. The key is to observe carefully the patient’s words and nonverbal cues and respond appropriately. The most effective response will vary by patient and situation, but will involve trial and error and will always require respect and trust.

Respect and trust are frequently invoked as integral aspects of ethics and professionalism in medicine [7]. Too often, however, respect is narrowly construed as “respect for autonomy.” In fact, the broader moral obligation imposed on health professionals is “respect for *persons*,” which ought to be independent of a patient’s personal characteristics and accorded equally to all, even to patients like Mrs. Williams who have been unsuccessful at weight loss.

Similarly, the role of trust in the patient-clinician relationship is often confined to a focus on the trust that patients should have in their physicians. But Katz prefers a model of mutual trust that extends from physician to patient, as well as from patient to physician. It is a trust that requires physicians “to trust themselves to face up to and acknowledge the tragic limitations of their own professional knowledge; their inability to impart all their insights to all patients; and their own personal incapacities...to devote themselves fully to their patients’ needs” [4]. Katz proclaims that if mutual trust were ever to govern physician-patient relations, the high rate of noncompliance with doctors’ orders would significantly decrease.

The capacities to respect and to trust are not easily acquired. Acknowledging Mrs. Williams’ life experience and knowledge of her body, inquiring about and listening

to her emotional experience (including the degree to which she feels frustrated and disrespected), gently disclosing some aspects of the clinician's own feelings and conflicts, and conveying confidence that her health can be improved, with or without major weight loss, may help to restore respect and trust in the relationship. Once the relationship is strengthened, an attempt to interest Mrs. Williams in specific, gradual steps towards weight control can be revisited.

## References

1. Schwartz MB, Chambliss HO, Brownell KD, et al. Weight bias among health professionals specializing in obesity. *Obes Res.* 2003;11(9):1033-1039.
2. Huizinga MM, Cooper LA, Bleich SN, et al. Physician respect for patients with obesity. *J Gen Intern Med.* 2009;24(11):1236-1239.
3. Hebl MR, Xu J. Weighing the care: physicians' reactions to the size of a patient. *Int J Obes Relat Metab Disord.* 2001;25(8):1246-1252.
4. Katz J. *The Silent World of Doctor and Patient.* 2nd ed. Baltimore, MD: Johns Hopkins University Press; 2002: 150.
5. Block JP, DeSalvo KB, Fisher WP. Are physicians equipped to address the obesity epidemic? Knowledge and attitudes of internal medicine residents. *Prev Med.* 2003;36(6):669-675.
6. Befort CA, Greiner KA, Hall S, et al. Weight-related perceptions among patients and physicians: how well do physicians judge patients' motivation to lose weight? *J Gen Intern Med.* 2006;21(10):1086-1090.
7. Beach MC, Duggan PS, Cassel CK, Geller G. What does 'respect' mean? Exploring the moral obligation of health professionals to respect patients. *J Gen Int Med.* 2007;22(5):692-695.

Lawrence J. Cheskin, MD, is associate professor of health, behavior and society at the Johns Hopkins Bloomberg School of Public Health in Baltimore, with joint appointments in the human nutrition program of the Bloomberg School's Department of International Health and in medicine at the Johns Hopkins School of Medicine. He graduated from Dartmouth Medical School and completed a fellowship in gastroenterology at Yale-New Haven Hospital. He founded and directs the Johns Hopkins Weight Management Center, a comprehensive treatment program for obesity. In his research, Dr. Cheskin has studied the effects of medications on body weight, how cigarette smoking relates to dieting and body weight, and the effectiveness of lifestyle and dietary changes in weight loss and weight maintenance.

Scott Kahan, MD, MPH, is the associate director of the Johns Hopkins Weight Management Center and core faculty in the General Preventive Medicine Residency Program at Johns Hopkins University in Baltimore. He specializes in public health aspects of obesity and clinical weight management.

Gail Geller, ScD, MHS, is a professor in the Department of Medicine at the Johns Hopkins University School of Medicine in Baltimore and core faculty in the Berman Institute of Bioethics. She has joint appointments in the Department of Pediatrics and the Bloomberg School of Public Health. Dr. Geller is a social scientist and ethicist

whose research focuses on communication, decision making, and well-being of patients, families, and clinicians under emotionally challenging conditions such as diagnostic uncertainty, cultural differences, power imbalances, and life-threatening illness.

**Related in VM**

[Weight Bias in Health Care](#), April 2010

[Diagnosing Obesity: Beyond BMI](#), April 2010

[“Can We Talk About Your Weight for a Few Minutes, Mr. Jones?”](#) April 2010

[Physician BMI and Weight Counseling](#), April 2010

*The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental.*

*The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.*

Copyright 2010 American Medical Association. All rights reserved.