



The importance of language in engagement between health-care professionals and people living with obesity: a joint consensus statement

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Obesity is a chronic condition that requires long-term management and is associated with unprecedented stigma in different settings, including during interactions with the health-care system. This stigma has a negative effect on the mental and physical health of people with obesity and can lead to avoidance of health care and disruption of the doctor–patient relationship. Considerable evidence exists to suggest that simply having a conversation about obesity can lead to weight loss, which translates into health benefits. However, both health-care practitioners and people living with obesity report apprehension in initiating this conversation. We have collaborated with stakeholders from Obesity UK, physicians, dieticians, clinical psychologists, obesity researchers, conversation analysts, nurses, and representatives from National Health Service England Diabetes and Obesity. This group has contributed to the production of this consensus statement, which addresses how people living with obesity wish to have their condition referred to and provides practical guidance for health-care professionals to facilitate collaborative and supportive discussions about obesity. Expert stakeholders consider that changes to language used at the point of care can alleviate the stigma of obesity within the health-care system and support improved outcomes for both people living with obesity and for the health-care system.

Introduction

Over 650 million people worldwide live with obesity, and twice as many people live with obesity than with overweight.¹ Prevalence has trebled over the past 40 years, resulting in approximately 4.7 million premature deaths per year in 2017.² These rates vary regionally, with the highest prevalence in the Americas where 62% of the population are living with obesity or with overweight.³ The UK has similar rates, with 28.7% of the adult population living with obesity and a further 35.6% with overweight.⁴ The debate regarding the status of obesity as a disease is one of the most polarising in modern medicine.^{5,6} Some people cite genetic, epigenetic, physiological, and neurohormonal differences as evidence that obesity should be regarded as a disease,^{6–14} whereas others suggest that the rise in obesity is a result of environmental shift towards convenience, socioeconomic deprivation, and the ready availability of processed high-calorie food.^{15–19} This consensus statement does not attempt to address this debate, rather tackle a far more immediate problem. Regardless of an individual's perception of obesity, whether disease or risk factor, there is general agreement that living with obesity is associated with a stigma culturally, through the media, or in engagement with the health-care system.^{20–23} This stigma is a global issue, having been described in North America, Australasia, and western Europe.²⁴ Understanding of the role of the genetic, biological, and environmental interactions in the development of obesity,^{25,26} and the biological mechanisms that maintain the bodyweight at a high so-called set point,^{27,28} is important to address to avoid the stigma and misconceptions that obesity is due to laziness and absence of will power.²⁹ A gap exists between scientific evidence and a conventional narrative of obesity, which is underpinned by these common misconceptions.³⁰

In a 2019 survey of 5623 respondents across four countries, 4442 (79%) people reported that they believed that obesity could be prevented and 4497 (80%) individuals stated that the condition could be treated by following a healthy lifestyle.³¹ Assumptions such as these, which focus on the personal responsibility of a person living with obesity, are a key way in which weight stigma is expressed.

Stigma can be defined as a strong feeling of disapproval from most people in a society about something, especially when this disapproval is unfair. Data suggest that this weight stigma can trigger physiological and behavioural changes that themselves contribute to poor metabolic health and further weight gain (figure).^{32,33} These changes include increased eating; reduced self-control; a 2.5 times increased likelihood of mood or anxiety disorders;³⁴ stimulation of cortisol, itself an obesogenic hormone; and avoidance of exercise.^{35,36} It has also been suggested that among people with obesity, those who experienced stigma had a 60% increased risk of mortality compared with those who did not experience stigma, irrespective of their body habitus.³⁷ Health-care professionals have the opportunity to address this stigma by leading through example with words and actions.

Intersectionality in weight stigma

The presence of obesity is marginally more common in men than in women and differs by ethnic origin.¹ Several studies have shown no difference in the attitudes displayed towards people of different race and gender;^{38–40} however, the response differed by personal characteristics, with women reporting higher weight bias internalisation than did men. Women of African American origin were more resilient to stigma and were less likely to develop eating disorders than were white American women.³⁷ For women of Hispanic origin, however, there was an association

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between weight discrimination and disordered eating.⁴¹ Paradoxically, although African American men were more resilient to stigma than were white American men, men who internalised bias were more likely to cope by excess eating, thus exaggerating the underlying condition.³⁷

The purpose of the consensus statement

In 2018, the National Health Service (NHS) England document on *Language matters: diabetes*⁴² brought together health-care professionals and people living with diabetes to outline the terminology that was appropriate for people living with the long-term condition. This document is one of many similar publications that have emphasised the importance of a collaborative approach with people who have multiple different chronic conditions, and the priority of person-first language.^{43–45} The publication has been well received by both health-care workers and people living with diabetes. On the basis of the document's success, we have collaborated with stakeholders from Obesity UK, physicians, dieticians, clinical psychologists, obesity researchers, conversation analysts, nurses, and representatives from NHS England Diabetes and Obesity to produce this consensus statement, which addresses how people living with obesity wish to have their condition referred to. Our aims are to improve engagement with health services and to ensure that they do not contribute to the problem, but, rather, take the lead on alleviating the stigma of obesity within global health-care systems.

The physiology of obesity

Obesity is widely accepted to be a risk factor for multiple conditions, such as hypertension, dyslipidaemia,

cardiovascular disease, type 2 diabetes, arthritis, some cancers, and depression,^{46–49} and is associated with reduced life expectancy and quality of life.⁵⁰ However, the underlying causes of obesity are poorly understood, even among health-care professionals. Two surveys found that a significant number of primary care professionals thought that the three most important causes of obesity were physical inactivity, overeating, and high-fat diet.^{31,51} These professionals accepted that other factors, such as the obesogenic environment, play a part; however, understanding of the disease's nature remained insubstantial.

The mechanisms of obesity are very complex.^{25,26,28} The hedonistic response to food is attenuated in people with obesity compared with individuals without obesity.^{13,52,53} Although multiple alterations in hormones of the brain have been identified, such as reduced protein YY,⁵⁴ attenuated ghrelin and leptin responses, and increased insulin and glucagon,⁵⁵ not every person living with obesity exhibits these alterations. The Foresight report of 2007⁵⁶ highlighted over 100 different biological, psychological, environmental, and social factors that potentially contribute to obesity. These factors range from genetic predisposition or neurochemical imbalances to emotional aspects, such as boredom or comfort eating, and complex social pressures that can start in childhood with having to finish a plate of food and continue throughout the life course with environments that can make healthy choices difficult.⁵⁶ The public health message of “move more, eat less” in the 2009–12 Public Health England “Change4Life” campaign⁵⁷ has re-enforced, if not trivialised, the complexity of the condition.

However, irrespective of the underlying cause, once weight gain occurs, the body resists any attempts at weight loss.⁵⁸ A normal physiological response to weight gain would result in a lowering of the metabolic rate and in the increase of hunger to maintain the new status quo.^{58–60} Thus, even when an individual successfully loses weight, weight regain occurs in most people and lifelong treatment is required to maintain the new normal weight.^{27,28} As such, obesity requires similar ongoing management to many other long-term conditions,⁶¹ yet is accompanied by a degree of stigma that is unprecedented.^{22,23}

In our opinion, the first step to combatting this stigma is to get the conversation right, whether that be between health-care professionals, when engaging with the general public, or in clinical encounters between a health-care professional and a person living with obesity.

The need for guidance: views of people living with obesity

Cultures that value inclusion and equality are generally considered to be the most successful ones. Nonetheless, the language used to describe people who are living with overweight or with obesity can have a profound effect on those individuals, leading to a type of discrimination

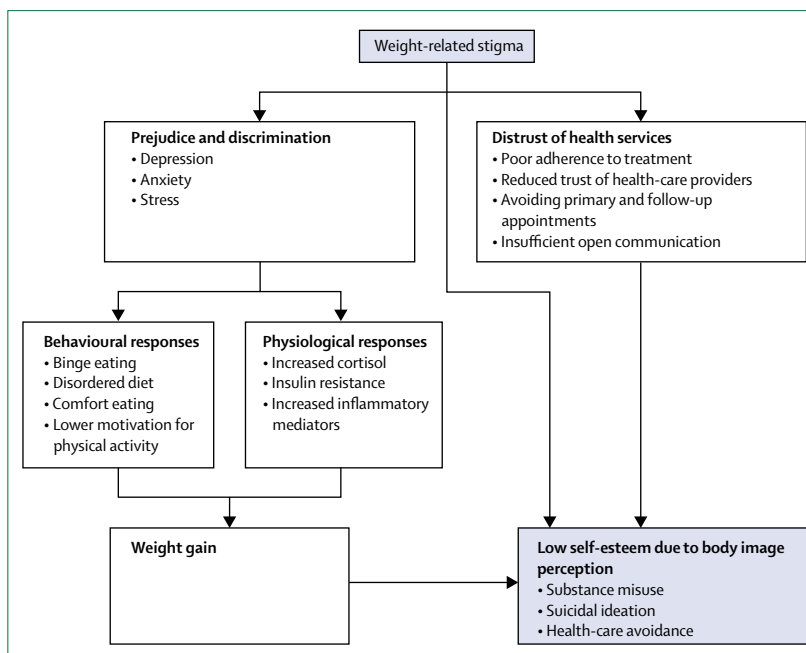


Figure: Potential mechanisms by which weight-related stigma might perpetuate obesity and contribute to the adverse health outcomes associated with obesity

that, in many instances, excludes individuals from leading what is considered by most people to be a normal life. People with obesity are stereotyped as individuals who are lazy and uneducated, do not have will power or self-discipline, binge eat, or eat too much, to name just a few.^{20,24,62}

The pervasiveness and ingrained nature of weight stigma and discrimination that is evident across education, workplaces, health care, and the media means that people living with obesity internalise these messages,⁶³ which can lead to physical and mental health problems, and maladaptive behaviours, such as the avoidance of health care.⁶⁴ In particular, specific words such as obese⁶⁵ and morbidly obese⁶⁶ have been reported to be perceived negatively by people with obesity, although commonly used by health-care practitioners. Many other terms were highlighted by our expert group, including words directed at the individual (eg, chunky) or generalisations referring to people with obesity as a drain on the NHS. Quantification of the frequency of these expressions is difficult, given that consultations with people with obesity are rarely audio or video recorded. However, from stakeholder experience, whether consciously or unconsciously, this biased language is pervasive in health-care systems. The overall tone of the conversation in a health-care setting is also important to people with diabetes, who emphasise the importance of tone of voice⁶⁵ and value being approached in a caring manner.⁶⁷ This established narrative of a simplistic cause of obesity, laying blame on the individual, is detrimental to the health of people living with obesity. To change the narrative, the theme of the 2020 World Obesity day, understanding and including the views of people living with obesity is paramount.

The need for guidance: views of health-care practitioners

Many studies have explored health-care practitioners' views and experiences of consulting with people with obesity.^{68–82} In these studies, practitioners state that they are aware of guidelines on obesity, but can be reluctant to follow them.⁷⁹ One reason for this reluctance is because they find the guidelines to be general and unspecific.⁷⁹ Health-care practitioners report insufficient knowledge on how to discuss weight^{79,83} and a need for further training to increase their skillset to address the issue of obesity.^{77,84,85} This inadequate knowledge translates into other key barriers when talking about obesity. Such barriers include practitioners not having confidence with the appropriate language to use,⁸³ and being concerned that they will cause offence or that the person with obesity will react negatively.⁸⁴ Health-care practitioners are also concerned of damaging their ongoing relationship with the individual^{84,85} and alienating them from seeking future care.⁸⁵ Providing practitioners with the clear and specific support requested, which addresses the scarcity of detail in standard guidelines, is one way to start to change the existing narrative, by targeting day-to-day clinical discussions.

Challenging the stigma

Addressing the stigma created by inappropriate use of language needs education^{86,87} to remind health-care practitioners that obesity is a chronic relapsing condition that requires support and realistic target setting. Language is generally seen to be the composite of both words and accompanying non-verbal communication. The stigma of obesity, however, expands beyond language and into the environment (panel). When attempting to improve our thought processes towards tackling this stigma, improving the setting of the consultation should also be considered. For example, appropriate large-size cuffs to measure blood pressure should be available and part of the work environment, rather than in the back of a cupboard only to be pulled out in special circumstances. Facilities should be available to measure weight, with permission, in a private room; although, this procedure should be the same for all individuals irrespective of their body habitus. Appropriately sized chairs should be the standard, with corridor width planned to facilitate free passage for those with a larger waist circumference. However, accommodating the environment for the challenges that arise is only a first step in addressing the issue of weight stigma.

Panel: General principles* for communication between a health-care practitioner and a person living with obesity to reduce stigma and improve the individual's wellbeing

Be positive

- Focus on the gains that might be accomplished by weight management, rather than the potential negative effects of failing to address obesity

Be helpful and supportive

- Offer specific help and advice where appropriate
- Signpost and guide people towards more information and local services
- Acknowledge that there are many routes to lose weight and that what works for one might not work for all

Be aware of non-verbal communication

- Talking about obesity is difficult; ensure that body language recognises this difficulty by engaging in a way that would be deemed appropriate for any other medical condition

Be collaborative

- Whenever possible, build meaningful and specific goals together
- Percentage change in weight or even weight neutrality should not be used as a goal, but rather a step towards reaching a meaningful person-centred outcome

Be understanding

- Up to 80% of obesity might be genetically determined
- Ensure not to attribute blame, but to acknowledge the difficulties faced by the person

Be environmentally aware

- Chairs with arms and weight limits can be restrictive
- Tight spaces with back-to-back chairs can be hard to navigate
- Appropriate medical equipment should be available, including scales that weigh up to 150 kg in a private space and a range of different sized cuffs to measure blood pressure

*Adapted from the NHS England guide by Partha Kar.⁴²

	How approach contributes to stigma	Suggestion of an alternative approach	Why alternative approach is preferred
"I'm sure the problems you've had are all related to your weight."	Immediately attributes blame for ill-health	"Would you mind if we spoke about your weight? Where do you think you're at?"	Open ended questions allow the opportunity to raise concerns and ask for advice
"You're a bit sort of on the chunky side, shall we say."	Non-clinical terms are perceived judgemental and disrespectful	"Some people with your symptoms, find that losing a bit of weight and a little exercise can be helpful."	The use of "some people" avoids attributing blame, while providing similar information
"Ideally your BMI, which is your height in relation to your weight, should be somewhere between 18 and 25.... between 30 and 35 you're considered clinically obese....from the measurements that you've had done today, you certainly fall into that category."	Implies that the individual is unaware of their weight	"And as you said, your weight's crept up a bit..."; "You said you'd like to lose some weight because you're feeling quite breathless..."	Can open up the conversation by use of the individual's own words
"At your weight, you really need to do more exercise."; "In terms of diet now, you obviously aren't following the diet sheet?"	Shows a lack of understanding of obesity, while attributing blame for the condition	"It's fantastic that you've taken up swimming. Don't worry that your weight hasn't come down yet, the benefit to your health goes beyond weight loss."	Positive feedback, even in the absence of measurable benefit, reassures an individual who might also be disheartened that their weight has not reduced

Resource adapted from the National Health Service England guide by Partha Kar.⁴² Quotations are adapted from real conversations.

Table: Examples of communication approaches used by health-care professionals that can unintentionally contribute to the stigma of obesity and alternative strategies suggested by people living with obesity

Data sources for compiling this guideline

Consensus statements, almost by definition, reflect opinion on how to manage a condition when an insufficient evidence base exists, by extrapolating evidence in similar populations. Although there is extensive literature regarding the methods of communication about weight management and behaviour change in clinical practice,^{88,89} a key source of this consensus statement comes from the inclusion of expert groups who live with obesity, represented by Obesity UK. After an initial stakeholder meeting, we used the academic literature to draft a working document. This draft was then sent to a working group, and comments and input from experts were invited. The document was then modified to reflect expert feedback. Following this stage, the iterated document was sent to the working group again. Comments and feedback on the structure, content, and key messages led to another refined version, capturing what the group prioritised as important for a health-care practitioner to say and avoid saying when consulting with a person with obesity. Discrepancies in opinion were resolved through discussion and, in all cases, priority was given to the views of people living with obesity. Below, we present the recommendations for conversations between a health-care practitioner and a person living with obesity that were highlighted through this working process.

Starting a conversation about obesity

There is extensive literature on the nature of good communication and engagement in general.⁹⁰⁻⁹² Starting a conversation well can allow for a helpful and positive discussion. However, the wrong opening statement can disengage the person living with obesity and set a tone

that cannot easily be rectified. Our group of experts identified relevant language features highlighted by people living with obesity that should be considered when starting a conversation about weight management (table).

Conversation features

Seeking permission

Unless introduced by the person living with obesity, before initiating the conversation, permission to discuss the individual's weight should be sought by use of an open-ended question to find out what the person thinks about their weight. This approach gives people not only the opportunity to raise concerns or ask for advice, but also to say that they do not wish to talk about their weight at this time. Before engaging in any opportunistic discussion about obesity during a consultation with another agenda, it is important to first address the individual's presenting concern.

Use of person-centred language

An individual should not be defined by their condition. Rather than saying the expression "an obese person", the phrase "person living with obesity" should be used. This distinction avoids labelling individuals by their condition and instead puts the individual first.

When possible, conversations should be started by referring back to topics that people have already mentioned. If someone has already mentioned their concern about an issue, highlighting this concern and suggesting how losing weight could help might be an appropriate way for a health-care practitioner to continue the conversation. This response shows that they have listened to the individual and sets up a collaborative conversation.

Use of language that is free from judgment or negative connotation

The threat of long-term consequences from obesity or scolding is unlikely to result in a change in behaviour. Instead, people respond better to a collaborative approach that uses the principles of coproduction exploring personally meaningful targets (eg, walking a daughter down the aisle without being short of breath), rather than to more construed targets of percentage bodyweight loss.⁹³ It should be remembered that the person living with obesity has a dual role as not only a patient, but also as an individual who should implement structured changes to their lifestyle. This understanding of personal targets (eg, playing football with children, dancing at the weekend etc) enables better engagement, while minimising authoritarian and controlling perceptions. A focus on the potentially negative aspects of not losing weight is less likely to be productive than is aspiring for positive outcomes.

Some words are unacceptable

Some words, phrases, and descriptions should be recognised as potentially problematic, whatever the intention of the user. This recognition does not solely apply during a consultation, but in the way that health-care workers communicate professionally to each other regarding the person with obesity. The position of the health-care professional in society gives the opportunity to lead by example and to generate acceptability for expressions that generate psychological distress for the recipient. Acknowledging that, although medically accurate, the term obese itself can be problematic is also important. In fact, none of the stakeholders in this group found the word obese unproblematic. Colloquially, the word obese has negative connotations and can be hugely stigmatising. Even though an accepted medical definition, obese should not be an acceptable adjective to use in a conversation, in the same way that an individual with cancer would not be described as cancerous during a consultation. Our expert group suggested that conversations about being overweight, or possibly carrying too much weight, are broadly acceptable terms, but only once permission has been sought.

Avoiding combat and humour

Avoiding use of combative language when referring to people's efforts to reduce overweight or obesity, and avoiding humour or ridicule is another key recommendation of the conversation. The use of so-called fat humour is pervasive in popular media with demeaning portrayals of people living with obesity,^{94,95} identifying them as different from the rest of society and contributing to their social isolation. For patients who experience many years of this demeaning humour, even well intentioned attempts can be regarded as a presentation of subconscious bias and draw distinctions

between the health-care professional and the person with obesity. These demarcations undermine attempts to work in a collaboration. Regardless of the intention, the use of this type of humour in a consultation awakens conscious or subconscious memories of isolation and is likely to damage relationships. Continuing to avoid this humour outside of the consultation is particularly important. The position of the health-care professional in society can serve to normalise this behaviour if they are seen to participate, but can also send a very clear message that it is unacceptable if objections are clearly voiced.

Sticking to the evidence

Communicating accurate and evidence-based information when discussing weight is essential. Health-care professionals often avoid talking about weight because they find these conversations difficult, worry about damaging the relationship between them and the person with obesity, or both. Various data exist to suggest that people are willing to speak about weight,⁹⁶ and speaking about weight and doing something about it are related. Evidence shows that after a brief conversation about weight, 96 (14%) of 711 people with obesity lost at least 5% of their body weight and another 53 (6%) lost at least 10%.⁹⁷ This 5% weight loss alone can reduce risk of cardiovascular disease and delay the age-related decline in microvascular disease that is exaggerated in people living with obesity.

Avoiding blame, but not generalising

Language that attributes responsibility (or blame) to a person for the development of their obesity or its consequences should be avoided—eg, by talking about some people, rather than saying the word “you” specifically, which gives space for people to think about how the statement could apply to them. However, language that implies generalisations, stereotypes, or prejudice should also be avoided. For example, “people like you struggle with exercise” imparts a generalisation on the individual you are with; whereas, “some people with obesity can find it difficult to exercise” allows the individual to think whether they fit into that mode.

No assumptions

Assumptions about diet and physical activity should not be made. Remembering that a person's weight might not reflect their diet and physical activity levels is essential. It should not be assumed that a person is inactive until they are asked about what they do. Changes in lifestyle should be applauded, no matter how slight, as this recognition is likely to stimulate further gains. Trivialising these efforts can demoralise an individual who has made considerable lifestyle modifications to produce relatively minor results. This language feature is particularly relevant during follow-up appointments when individuals report a change to diet and lifestyle, but minimal anthropomorphic improvements have been

made. The natural history of a person living with obesity is that weight will progressively increase. Maintaining a stable weight is an achievement for many people.

Talking about obesity and overweight with children and young people

The global prevalence of children and adolescents aged 5–19 years who are living with overweight or with obesity has risen from around 4% in 1975 to around 18% in 2016.¹ A gender disparity exists in that 22.5% of boys aged 10–11 years were living with obesity in the 2018–19 school year, compared with 17.8% of girls the same age.⁹⁸ Weight-based teasing is associated with marked psychological disturbances for children and young adults. Like their older peers, girls are more susceptible to depression than are boys.⁹⁹

Generally, the recommendations in this consensus statement are relevant for all health-care practitioners working with any age group of individuals living with obesity. However, conversations about growth and weight with young people, and the adults accompanying them, can be particularly sensitive as they both might be concerned to hear that they have obesity or overweight. Parents who seek weight loss treatment for their children find themselves conflicted between double moral burdens, in which they are blamed and shamed for the weight itself, and are culpable for the psychological effects of encouraging weight loss. These concerns should be listened to first, before any advice is given. If advice is provided, collaborating with the young person, the adults accompanying them, or both, is important. Health-care professionals should remember that parents of children with obesity often have personal weight problems themselves.¹⁰⁰ This occurrence further adds to parental stigma, as parents are not only responsible for the effect they have on their children, but also themselves. Assumptions about their behaviours should not be made and, instead, their input and thoughts should be invited. Statements such as “other young people have said x” or “some young people say y” can help to show the person that they are not alone. All these considerations, particularly regarding blame and generalisability, are pertinent to younger individuals (aged <19 years) with obesity. These

conversations can shape the physical and mental wellbeing of an individual for decades to come. Thinking carefully about focusing on small positive changes, rather than negatively commenting on current behaviours, is crucial for ongoing engagement with the individuals.

Guiding and signposting

Once the topic has been raised, available guidance and signposting are important. Although this conversation can, or should, occur in any environment that the individual feels comfortable enough to give consent for discourse, this setting might not have trained experts immediately to hand. Health-care workers should familiarise themselves with local sources of information and support. When signposting, people living with obesity should be reminded that they might need to try different things to find out what works for them. These individuals should also be reassured that there are multiple, different dietary interventions that have been shown to be beneficial to some individuals, although, reported figures are all for average weight loss. As with all interventions, these findings mean that some people with obesity do not respond and, therefore, should not become disheartened if the intervention is unsuccessful. Acknowledging positive actions, even if these have not resulted in a change in weight or waist circumference, is important. Weight loss often comes some time after changes in lifestyle, and obesity is a chronic progressive disease; therefore, for many people, weight neutrality might be regarded a success in arresting this progression.

Obesity is a chronic relapsing condition and no quick fix exists. Health-care professionals should mention that they are there to help. People living with obesity should be informed that if they try something and it does not work for them, they can come back and make a new plan with the health-care practitioner. Threatening about the risk of future complications is not helpful; however, working towards preventing the risk associated with obesity might positively help to avert future problems.

Conclusions

Obesity is a long-term chronic condition that is associated with multiple comorbidities. Tackling the condition remains a priority for global health-care systems. However, to overcome obesity successfully, an approach that engages people living with obesity is essential. People living with obesity commonly experience stigma during interactions with health-care professionals, who often talk about obesity in ways that are unhelpful or can cause offence. This stigma can negatively affect the mental and physical health of an individual living with obesity and result in them not engaging with the health-care system.

The language used to discuss the condition and counsel people living with obesity is of paramount importance for achieving long-term benefits. Health-care professionals can have a major role in reducing the obesity stigma within global health-care systems by getting the

Search strategy and selection criteria

We identified references for this consensus statement through searches of PubMed for articles published from Jan 1, 2000, to Dec 20, 2019, using the search terms “obesity”, “obese”, “weight” or “overweight” in combination with the terms “stigma”, “perception”, “language”, and “conversation”. We also identified relevant articles through searches of the reference lists of the identified literature. We reviewed articles resulting from these searches and relevant references cited in those articles and included articles published only in English.

conversation right with people with obesity. However, health-care professionals have said that they avoid the topic and stated a need for more specific support in discussing obesity.⁸⁴ In this consensus statement, we have drawn on expert opinion, including the experiences of people living with obesity, to address this need. We have identified clear examples of what language might be best used and what might be best avoided, and the manner in which conversations should be guided. Education for health-care practitioners on the underlying causes of obesity and the use of appropriate and helpful language have been shown to improve the health-care experience of people living with obesity. By increasing awareness and using appropriate and helpful language that comprises collaborative discussions, health-care professionals can play a role in reducing the obesity stigma across wider health-care systems.

Contributors

CA and WDS coproduced the first and subsequent drafts of this consensus statement. SLB led the section on engagement with people living with obesity. JL, CL, and AT contributed to each section based on the feedback from their respective networks. All authors have read and approved the final version.

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