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CASE AND COMMENTARY

How Forcefully Should Clinicians Encourage Treatment When Disagreement Persists About Obesity Risk?

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Abstract

Pediatric obesity is a major public health problem, and weight reduction in children and adolescents with obesity is associated with improvement in health outcomes. This case of an adolescent diagnosed with obesity whose mother disagrees with the diagnosis illustrates challenges often encountered in clinical practice, including (1) diagnosing a disease in an asymptomatic patient whose future risk for negative health outcomes is uncertain, (2) addressing ethical implications of naming a stigmatizing disease, and (3) resolving conflicting goals and opinions of a patient, caregiver, and physician. Suggestions for navigating disagreement and implementing courses of action are discussed.

Case

Ms D presents with her daughter, Ms W, for an adolescent medicine appointment with Dr N. Ms W is 14 years old and on weigh-in at Dr N's office has a recorded weight of 175 pounds and a height of 5'1''. As Dr N reviews Ms W's records, he notes that her body mass index (BMI) is 33 and discusses with Ms D and Ms W that Ms W meets criteria for being labeled *obese*. He reviews with Ms W and Ms D the long-term ramifications of obesity and encourages the patient to enact a diet and exercise routine with a goal of losing 10% of her body weight over the next year. At that same appointment, Dr N obtains a hemoglobin A1c (6.0), a total cholesterol of 310, and verifies that thyroid stimulating hormone levels are within normal limits.

At her next visit 1 year later, Ms W excitedly reports to Dr N that she has joined the track team and has been running 3 miles a day and lifting weights. She notes that she has been eating more protein and has mostly stopped eating candy. Her weight at this visit is 191 pounds and her BMI is 36. Dr N discusses with Ms D and her daughter that her BMI now defines her as *morbidly obese*. Although she is young for bariatric surgery, Dr N notes that she has already made a myriad of lifestyle modifications to no avail and should strongly consider bariatric surgery in an effort to prevent the long-term sequelae of obesity.

Ms D refuses the bariatric surgery referral, stating that her daughter is healthy—she has prediabetes but her blood pressure is excellent. "We are all big in my family—bigger than

my daughter by a lot. My grandmother is 85 years old and 300 pounds, and I'm not going to let a skinny doctor tell me or my family we aren't healthy just the way we are." Ms W isn't sure she wants the surgery but when her mother leaves the room, she does report to Dr N that she wishes she was thinner because she is being made fun of by people in school.

Commentary

Pediatric obesity is a major public health problem currently affecting approximately 17% of US children and adolescents.[1] Weight reduction in children with obesity is associated with improvement in cardiometabolic outcomes, including decreasing risk for development of type 2 diabetes, hypertension, and dyslipidemia.[2] Therefore, it is essential for physicians to counsel patients and families effectively regarding the risks of obesity and the importance of lifestyle changes. Challenges in counseling youth in these situations are compounded when lifestyle modifications prove insufficient and future health risks are uncertain. The patient-clinician relationship is best served by a collaborative approach to weight management strategies, especially when a clinician suggests alternative weight management treatments such as medication or bariatric surgery that have risks.

Should Physicians Have Power to Name Obesity as a Disease?

In this case, the physician labels the patient as obese based on her BMI,[3] and when her BMI has increased one year later, he notes that she is morbidly obese. In using these labels, the physician classifies the patient as having a disease requiring treatment. This classification serves as the basis for his further recommendations for lifestyle modifications, and, ultimately, for a more extreme intervention—bariatric surgery—when those lifestyle modifications do not result in measurable improvements. The mother responds as many parents would in this situation: she denies that her daughter demonstrates any manifestations of true disease, stating that her daughter is "healthy" overall and has excellent blood pressure. As the mother implies, prediabetes does not inevitably lead to diabetes in all cases.[4]

There has been considerable debate regarding whether obesity should be called a disease. The Obesity Society supported the classification of obesity as a disease in 2008,[3] and the American Medical Association officially recognized obesity as a chronic disease in 2013.[5] But should physicians have the power to diagnose a disease when future morbidity and mortality are not guaranteed? As the patient's mother indicates in her emphatic reaction, it is possible for a person with obesity, such as the patient's grandmother, to "beat the odds" and show no signs of obesity-related complications at 85 years of age.[6] While the patient's laboratory results meet criteria for diagnoses of prediabetes and hyperlipidemia, she remains asymptomatic. Even with prediabetes and hyperlipidemia, it remains unknown whether she will eventually go on to develop overt complications. As the mother implies, BMI alone is not always the best indicator of health status.[7]

Ethical Considerations in Diagnosing Obesity in an Adolescent Patient

Despite the possibility that this patient could "beat the odds," it is the physician's responsibility to provide recommendations based on the most probable outcomes. With increasing BMI and prediabetes, this patient is undoubtedly at high risk for adverse health outcomes. By diagnosing her as obese and thus naming a disease, the physician is better able to recommend appropriate, evidence-based treatments. Moreover, by naming obesity as a disease—effectively acknowledging that the patient cannot entirely control her weight through behavioral choices and willpower—the physician might be attempting to reduce the stigma and shame often associated with obesity, as Ms W is being bullied in school regarding her weight. In our society, stereotypes unfortunately persist that persons with obesity are lazy, unmotivated, or lacking in discipline. In naming obesity as a disease, numerous professional societies including the Endocrine Society,[8] the Pediatric Endocrine Society,[9] and the Obesity Society[10] have recognized the complex genetic and environmental factors that contribute to overweight and obesity. Persons with obesity, as with any other chronic disease, should not be blamed for their medical condition. This argument has helped facilitate expansion of research, medical treatments, and insurance coverage for obesity and its complications.

But is it ethical for the physician to use the words *obese* and *morbidly obese* when talking to a patient, particularly when the patient is a child or adolescent? While it is certainly beneficial for the physician to use these labels for the purpose of diagnostic coding in the medical record, he can choose to use different terminology when conversing with the patient and her parent. In studies of patient and parental perceptions of words commonly used to describe excess body weight, the terms *fat*, *obese*, and *extremely obese* were rated as undesirable and stigmatizing compared to terms like *unhealthy weight* or *BMI*.[11,12] The physician in this case referred to Ms W's elevated BMI, thereby using a term that is less stigmatizing, but then proceeded to explain that her BMI defines her as "morbidly obese," a more stigmatizing and undesirable term. The Obesity Society recommends using people-first language to reduce the use of potentially stigmatizing words; for example, the physician should say "a child with obesity" rather than "an obese child."[13] Additional research could help further elucidate how health care practitioners can discuss weight management using sensitive, neutral, and patient-friendly language.

Ethical Issues in Acknowledging Obesity as a Problem

In this case, the physician is recommending bariatric surgery, an invasive procedure that entails known risks with unclear benefit to the patient. While there is some evidence of effectiveness of bariatric surgery for weight loss in the adolescent population,[14] current pediatric obesity guidelines recommend bariatric surgery only in cases in which the patient meets certain developmental and other criteria and "has a BMI of > 40 kg/m^2 or has a BMI of > 35 kg/m^2 and significant, extreme comorbidities."[8] This patient currently has a BMI of 36 kg/m^2 and prediabetes without extreme comorbidities, and it is not possible to predict with precision her future risk for development of complications.

The principle of nonmaleficence—to "first, do no harm"—is one of the pillars of medical ethics and could justify the mother's preference not to pursue bariatric surgery. In this case, the daughter does not presently have any serious comorbidities, and it cannot be concluded that there is risk for imminent harm if the mother elects for no interventions. Indeed, many well-informed and reasonable caregivers would not choose to follow this physician's recommendation for bariatric surgery at this time, instead opting for continued efforts at positive lifestyle changes. Although it is unclear from the case description how actively the mother is encouraging her daughter's efforts to improve her diet and physical activity, the daughter has clearly been able to make several positive changes. Furthermore, the family is appropriately utilizing health care services through regular yearly visits.

By noting that obesity is typical in the patient's family and not always associated with poor health or reduced lifespan, the mother could be seeking to normalize her daughter's weight and thus reduce the stigma associated with obesity. She questions the ability of "a skinny doctor" to empathize and provide unbiased care. Her skepticism could be valid, as evidence has suggested that physicians often share society's negative stereotypes regarding persons with obesity.[15] And research has shown that health care professionals demonstrate both implicit and explicit biases when seeing patients with obesity.[16] Although the physician in this case does not show any obvious signs of prejudice, he should constantly strive to be aware of his unconscious biases and the potential subtle ways that they can impact care delivery. The patient and her mother might no longer wish to interact with health care professionals if they experience prejudice. Being stigmatized by the physician might precipitate the patient's feelings of shame and lead to her becoming depressed. The physician, in taking a collaborative approach, would be more likely to lead to an improved relationship with Ms D, as discussed below. He should address Ms D's concerns regarding bariatric surgery and discuss the risks and benefits. Since there is no medical consensus that bariatric surgery is needed, he should abide by Ms D's decision.

Navigating Parent-Clinician Disagreements About Pediatric Obesity Treatment

This patient's case highlights 2 areas of disagreement often encountered by clinicians in pediatric practice: between physician and parent and between parent and child. The recent Endocrine Society clinical practice guidelines on pediatric obesity strongly suggest that a clinician's obesity prevention efforts "enlist the entire family rather than only the individual patient."[8] This family-oriented approach, however, can only yield desired outcomes when caregivers and other family members are motivated participants in the treatment plan. The mother in this case does not currently acknowledge the potential risks of her daughter's obesity, defensively insisting that her daughter is "healthy."

The physician should start by recognizing his and the mother's common goals in order to partner with her and keep her as an ally in her daughter's care. Undoubtedly, both the mother and the physician desire to promote good long-term health and quality of life for

the patient. While praising the patient for joining the track team and selecting healthier foods, the physician should acknowledge the supportive role the mother has likely had in fostering her daughter's behavioral changes. Through continued dialogue over the course of frequent follow-up visits, the physician could eventually help the mother understand that her daughter is at high risk for future comorbidities.

While the patient expresses desire to be thinner, it is unclear whether her primary motivations for weight loss are well aligned with the physician's intentions. In his counseling, the physician emphasizes the potential long-term health consequences of obesity. The patient, however, voices fear of bullying as a significant factor contributing to her desire to lose weight. Particularly when counseling adolescents, physicians must consider how social stigma and poor body image can influence patients' eagerness to engage in treatment.[13] One study found that over half of adolescents seeking weight loss treatment had experienced weight-based victimization, including pervasive teasing and bullying.[16] It is essential for the physician to encourage weight management efforts while addressing concerns about bullying and promoting development of a healthy body image.

The physician should continue to promote the patient's demonstrated efforts at healthy lifestyle changes. Follow-up visits every 3 to 4 months would also give him the opportunity for continued discussion with Ms D regarding her daughter's health and potential interventions to help her with weight reduction. An interdisciplinary approach to management could be helpful, with a team including a nutritionist, physical activity specialist, and social worker or psychologist. Counseling services could also be particularly beneficial in addressing the bullying that the patient has experienced. However, community resources, if they exist, might be more acceptable to Ms. D and easier to access than services offered in a health care setting.

In summary, ethical challenges arise in caring for a teenager with obesity. Prejudices regarding obesity might incline some health care professionals to be overly zealous in recommending treatments that are controversial, such as bariatric surgery. However, medicalization of obesity can reduce the stigma associated with it within the medical community. By clinicians' naming obesity as a disease, a patient with obesity might no longer feel guilt or shame regarding her weight, and societal imposition of blame for obesity might be reduced. It is essential for health care professionals to approach patients with obesity with compassion and to avoid using terminology that is stigmatizing or offensive. A collaborative approach is needed when there are conflicting goals and opinions among the physician, patient, and parent.

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Editor's Note
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