FROM THE EDITOR

What’s Wrong With Overreliance on BMI?
Kratiika Mishra and Astrid Floegel-Shetty, MA

I yearn for more than neutrality, acceptance, and tolerance—all of which strike me as meek pleas to simply stop harming us, rather than asking for help in healing that harm or requesting that each of us unearth and examine our existing biases against fat people.

Aubrey Gordon

US adults classified as obese, estimated to compose 42.4% of the US population in a 2017-2018 survey, captivate public discourse because of the sustained scholarship outlining the adverse health outcomes (such as postulated risk of cardiovascular disease, diabetes, and cancer) and the economic consequences (including projected spending on health care) of being obese. A diagnosis of obesity is primarily reliant on body mass index (BMI), which is calculated by dividing an individual’s weight in kilograms by the square of their height in meters. BMI serves as a metric for health status; it influences diagnostic workup, differential diagnosis, intervention selection, and outcome measurement.

Current use of BMI as an evaluative and predictive tool is troubling. Originally conceived as a practical index of relative body weight, BMI is now wielded in medicine as a heuristic for disease and health risk, despite studies showing that BMI can be (1) an inaccurate proxy for cardiometabolic markers of health (eg, blood pressure, cholesterol levels) or lifestyle factors (eg, physical activity, eating habits) and (2) imprecise in its prediction of health risks when applied to the diversity of human bodies. Beyond BMI being a poor identification tool, the stratification of care by patients’ BMI is ethically troubling because it reinforces narratives justifying anti-fat attitudes and discrimination within systems and individual interactions.

Reliance on BMI as a diagnostic metric also narrows what medicine accepts as “healthy” bodies—those perceived as not fat—with wide-ranging consequences. On one hand, the “weight-normative approach” to medicine, which emphasizes the roles of weight and personal responsibility for health, perpetuates misunderstandings about the phenotypes of and potential resolutions for obesity. Without consideration of individual clinical presentation, bodies with a BMI greater than 30 are automatically labeled as obese, and weight loss is often recommended as the treatment option despite its unsustainability and impermanence. On the other hand, health care quality is undermined by the assumption that “normal weight” bodies are the benchmark of health. This assumption manifests in inequitable eligibility criteria for clinical trials that influence the generation of evidence for standards of care, iatrogenic harm born of
anti-fat biases during care delivery, and a moral panic that, to our collective and individual detriment, pursues oversimplified and imprecise efforts during care administration to promote thinness and eliminate fat bodies that pose a supposed epidemic-level threat.

This issue of the *AMA Journal of Ethics* focuses on ethical dimensions of how BMI is clinically deployed. Specifically considered are BMI screening practices for gender-affirming surgeries, pharmaceutical interventions for adolescents classified as obese on the basis of BMI, historical and current uses of BMI in enforcing power inequity, and the exclusion of people with higher BMIs from clinical trials. Through exposure to this slate of thoughtful perspectives, we hope that readers of this issue of the *AMA Journal of Ethics* will come away with an enriched understanding of how the overuse of BMI in medical practice detrimentally leads to weight being disproportionately valued in our conception, assessment, and promotion of health.

References


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