The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

ACOG COMMITTEE OPINION

Number 763

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Committee on Ethics

This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Ethics in collaboration with committee members Sigal Klipstein, MD, and Ginny L. Ryan, MD, MA.

Ethical Considerations for the Care of Patients With Obesity

ABSTRACT: Obesity is a medical condition that may be associated with bias among health care professionals, and this bias may result in disrespectful or inadequate care of patients with obesity. Obstetrician–gynecologists regularly care for patients with obesity and play an integral role in advocating for best practices in health care and optimizing health outcomes for patients with obesity. Obstetrician–gynecologists should be prepared to care for their patients with obesity in a nonjudgmental manner, being cognizant of the medical and societal implications of obesity. This Committee Opinion has been updated from its previous version to focus on obesity bias within the medical community and to provide practical guidance using people-first language instead of labels (ie, "patients with obesity" versus "obese patients") to help obstetrician–gynecologists deliver effective, compassionate medical care that meets the needs of patients with obesity.

Recommendations and Conclusions

Based on the principles outlined in this Committee Opinion, the American College of Obstetricians and Gynecologists (ACOG) provides the following recommendations and conclusions for the care of patients with obesity:

- Obesity is a medical condition and should be treated as such. Obstetrician–gynecologists should focus on patient-centered counseling regarding the medical risks associated with obesity and on concrete strategies and goals to improve overall health.
- Obstetrician–gynecologists should be mindful of the tendency to harbor implicit bias toward patients with obesity, engage in self-reflection to identify any personal implicit bias, and take steps to address any identified bias to help ensure that it does not interfere with the delivery of respectful clinical care for patients with obesity.
- Obstetrician–gynecologists should advocate within their clinics and institutions for the best possible resources to provide optimal care for patients with obesity.
- It is unethical for obstetrician–gynecologists to refuse to accept a patient or decline to continue care that is within their scope of safe practice solely based on an arbitrary body mass index (BMI) cutoff or because the patient has obesity.
- Although obesity is not an indication for the transfer of routine obstetric or gynecologic care, consultation with or referral to physicians with expertise in obesity may be appropriate if the obstetrician–gynecologist cannot safely and effectively care for the patient because of a lack of specialized training, experience, or institutional resources.
- Beginning early in their training, it is important to provide medical trainees with the skills needed to treat patients with obesity effectively and to communicate openly and in an unbiased manner about obesity.

Introduction

Obesity is a medical condition defined by having a BMI (calculated as weight in kilograms divided by height in meters squared) of 30 or more (1), and is further divided

into classes I–III (2, 3). The rate of obesity in the United States has increased rapidly over the past several decades (4, 5), with approximately two out of every five women in the United States currently identified as obese (6). Weight-related bias and stigma in society and in medical institutions may affect the medical care provided to patients with obesity. These issues are heightened in the obstetric–gynecologic setting because of the intimate nature of the clinical encounter (7). Obstetrician–gynecologists regularly care for patients with obesity and play an integral role in advocating for best practices in health care and optimizing health outcomes for patients with obesity. This Committee Opinion has been updated from its previous version to focus on obesity bias within the medical community and to provide practical guidance using people-first language instead of labels (ie, "patients with obesity" versus "obese patients") to help obstetrician–gynecologists deliver effective, compassionate medical care that meets the needs of patients with obesity.

Background

Medical Complications of Obesity

Although not all patients with obesity will experience negative medical sequelae because of their obesity, obesity is a medical condition that significantly increases the risk of adverse medical outcomes throughout a patient's life, particularly for those with other comorbidities (2). Obesity is associated with higher rates of diabetes, hypertension, high cholesterol, stroke, heart disease, certain types of cancer, and surgical complications such as wound infections and venous thromboembolism (8, 9). Obesity in pregnancy is associated with an increased risk of early pregnancy loss, prematurity, stillbirth, fetal anomalies, fetal macrosomia and low birth weight, gestational diabetes, hypertension, preeclampsia, cesarean delivery, and postpartum weight retention (10, 11). Obstetrician–gynecologists should be aware of imaging and testing scenarios that are technically limited by obesity, such as prenatal ultrasound evaluations, and factor this into clinical decision making.

Increased Costs and Health Care Resource Utilization

Direct and indirect costs arising from the medical care, increased morbidity and mortality, and decreased productivity related to obesity create a significant economic effect on the U.S. health care system (12). For example, the number of sick days and medical claims increase as a person's BMI increases (13), and adults with severe or morbid obesity (BMI more than 40) have per capita health care costs that are 81% higher than those of healthy-weight adults (14).

At times, the care of patients with obesity will require obstetrician–gynecologists to expend more time and medical resources. It may require the availability of specialized equipment, such as large speculums, examination tables that can accommodate a higher maximum weight, and specially designed instruments for use in the operating room. Additionally, surgical procedures that often are performed in more cost-effective outpatient surgical centers may need to be undertaken in hospitals because of increased anesthesia risks to patients with obesity, along with other medical considerations. These surgical procedures may be more complex, and they may be of longer duration. During pregnancy, more frequent ultrasonography may be required to monitor fetal growth and presentation because of an inability to assess such factors with routine physical examination alone. Extra time may be necessary to counsel women with obesity regarding minimizing their increased medical risks.

Societal Stigmatization of Obesity

Obesity is a highly stigmatized condition in modern society (15). Society stigmatizes women whose bodies fall outside of a perceived norm (16) even though weight is a continuum, and there is not a BMI cutoff at which a person crosses from being healthy to unhealthy. In many cases, people with obesity are blamed for irresponsible overeating or inactivity, or both. Patients with obesity also face barriers to optimal care that arise from obesity bias in our society and in our medical institutions (15, 17).

Physician Implicit Weight Bias and Effect on Patient Care

There is increasing evidence of weight bias in health care settings (18). This bias may be related to the increased medical risks, costs, and resource use as well as the societal stigma related to obesity. Physician weight bias often is implicit and beyond physicians' immediate awareness, making it difficult to identify and remedy. For example, this negative bias has been reported even among physicians who specialize in treating patients with obesity (19). And sometimes, a physician's own BMI may be a source of weight bias (20).

This implicit bias toward patients with obesity may manifest as blame for their weight and a perception that these patients are "annoying" and a "greater waste of their time" (21, 22). Such negative attitudes and biases place the patient–physician relationship at risk by reducing patient satisfaction and the quality of the patient encounter, which can lead to negative patient outcomes (18). Physicians may demonstrate less emotional rapport (23), be less likely to engage in patient-centered counseling and care, and spend less time during the clinical encounter with patients with obesity (18). Physician weight bias may result in delayed diagnosis and treatment because of physician over-attribution of patient symptoms to obesity (18). Patients with obesity also may avoid or delay getting needed clinical care if they have experienced bias or stigmatization from their physician, which may lead to poorer overall health or

faster progression of medical conditions that have been left untreated (18).

Obstetrician–gynecologists should be mindful of the tendency to harbor implicit bias toward patients with obesity, engage in self-reflection to identify any personal implicit bias, and take steps to address any identified bias to help ensure that it does not interfere with the delivery of respectful clinical care for patients with obesity. Box 1 includes questions for self-reflection to help obstetrician–gynecologists identify implicit bias.

Patient-Centered Counseling to Address Obesity

Obstetrician–gynecologists may find it difficult during a typical office visit to initiate a dialogue about weight, healthy diet, and lifestyle, especially when other problems must be addressed or if the patient is not receptive to lifestyle change (8). The use of the following patient-centered communication strategies and guidance can help establish rapport and engage the patient in health care decision making. Multiple discussions may be needed to facilitate an open dialogue and to collaborate with the patient to develop an individualized plan to achieve her desired health, diet, and physical fitness goals.

Encourage Healthy Behaviors Among All Patients

Body mass index should be calculated as a standard part of all patient care interactions. During routine care and prenatal care visits, all patients should be assessed for and counseled on physical activity, diet and nutrition, including an assessment for obesity and eating disorders (24). When obstetrician–gynecologists follow these standard practices routinely, it is less likely that patients with obesity will be singled out or stigmatized, and obstetrician–gynecologists also may become more comfortable discussing weight as an important medical indicator.

Focus on Medical Risks and Address Overall Health

Obesity is a medical condition and should be treated as such. The American College of Obstetricians and Gynecologists and the American Medical Association agree that obesity is a medical condition, not a moral failing (25). Appropriately defining obesity as a medical condition helps focus the approach to obesity on helping physicians and patients address the disease and its clinical sequelae (26). Obstetrician–gynecologists should focus on patient-centered counseling regarding the medical risks associated with obesity (see "Medical Complications of Obesity" earlier in this document) and on concrete strategies and goals to improve overall health. Obstetrician–gynecologists should familiarize themselves with the degree of risk that an elevated BMI confers and should be prepared to discuss those risks with their patients in an unbiased manner (2, 27). In doing so, obstetrician–gynecologists should address not just weight loss, but rather the patient's overall health, her understanding of risks associated with obesity, and her desires regarding weight management. Obstetrician–gynecologists can help prevent negative reactions to their recommendations by focusing on the medical rationale for their advice. See Box 2 for suggestions on how to introduce a clinical discussion of weight.

Use People-First Language

The term "obese patient," which suggests that obesity defines the patient, should be avoided in favor of people-first terminology, such as "patient with obesity," which identifies a patient as having the condition of

Box 1. Questions to Help Identify Implicit Weight Bias

- Do I make assumptions based only on weight regarding a person's character, intelligence, professional success, health status, or lifestyle behaviors?
- Am I comfortable working with people of all shapes and sizes?
- Do I give appropriate feedback to encourage healthful behavior change?
- Am I sensitive to the needs and concerns of individuals with obesity?
- Do I treat the individual or only the condition?

Data from The Obesity Society. Obesity, bias, and stigmatization. Available at: http://tosconnect.obesity.org/obesity/resources/facts-about-obesity/bias-stigmatization. Retrieved August 27, 2018.

Box 2. Conversation Starters for Discussing Weight With Patients

- "Could we talk about your weight today?"
- "How do you feel about your weight?"
- "Has your weight fluctuated up or down over the past year?"
- "Are you aware of the effect of weight on (eg, surgical risks, menstrual cyclicity, pregnancy, fertility)?"
- "I would like to discuss your specific health risks, including (weight and any other particular risks)."
- "Do you feel that you are overweight or underweight?"
- "Do you have access to healthy foods?"
- "Are you able to find time and a safe space for exercise?"

obesity (28). The terms "morbidly obese," "fat," and "obese" have been found to be the most stigmatizing, whereas "weight problem," "unhealthy weight," and "high BMI" have been found to be the most motivating and least offensive language options for discussing weight with patients (29). However, all weight-based terminology may be associated with some level of stigma, and individual preferences may vary (29). Therefore, it may be helpful to ask the patient which terms are preferred when discussing body weight (29). Although more sensitive language is recommended when speaking with the patient, medical terminology and diagnoses such as "overweight," "obese," and "morbidly obese" should still be used, as appropriate, in the medical record and for billing and coding purposes.

Exhibit Empathy, Sensitivity, and Support

Obstetrician–gynecologists should understand that patients with obesity may have had negative experiences with other health care professionals regarding their weight, and they should approach the topic with sensitivity, empathy, and an understanding of the emotional consequences of obesity stigma (30). It is important for obstetrician–gynecologists to be able to discuss weight without displaying uneasiness and to accept the patient's attitudes without showing irritation or intolerance. The goal is to consider patient perspectives and incorporate them into clinical decision making, as appropriate.

Use Motivational Interviewing to Encourage Healthy Lifestyle Changes

Obstetrician–gynecologists should acknowledge the difficulty in making lifestyle changes and counsel patients that even small weight losses can result in significant health benefits (30). Motivational interviewing, a patient-centered counseling approach that encourages patient participation through listening and active exploration of uncertainties, has been successfully used within the clinical setting to promote weight reduction, dietary modification, and exercise. Motivational interviewing helps patients to identify the thoughts and feelings that cause them to continue unhealthy behaviors and to develop new thought patterns that will lead to healthy behavior changes. For more information on the principles and practice of motivational interviewing, see ACOG Committee Opinion No. 423, *Motivational Interviewing: A Tool for Behavior Change* (31).

It is important for obstetrician–gynecologists to consider the various social conditions that affect the prevalence of obesity when counseling patients concerning their weight. Many women, irrespective of demographic characteristics or income, are vulnerable to becoming overweight or obese because of limited resources for physical activity and healthy food choices, work commitments, and family demands (8). It also is important to keep in mind that many patients have already tried to lose weight, often repeatedly.

Some patients may view even empathic, motivational weight-loss counseling as biased and paternalistic (32, 33). Obstetrician–gynecologists may experience resistance when discussing weight loss with patients with obesity if weight is an important part of their identity and not seen as actionable (26, 34). Other patients with obesity may have considered the pros and cons of weight loss compared with maintaining their current lifestyle and decided that the balance favored obesity. Obstetrician–gynecologists can best serve their patients with obesity by trusting and respecting their decisions even when patients with obesity do not follow medical advice to engage in weight-loss strategies (35).

Considerations for Creating a Supportive Clinical Setting

Safe, effective, and compassionate care of patients with obesity may require special considerations in the clinical setting. Obstetrician–gynecologists should advocate within their clinics and institutions for the best possible resources to provide optimal care for patients with obesity. A supportive clinical setting for patients with obesity optimally includes comfortable, accessible waiting and examination areas with weight-sensitive reading materials; specialized medical equipment, such as long vaginal specula and specially designed tables and surgical equipment; and sensitive weighing procedures, including a private weighing area (36).

Consultation and Referrals

It is unethical for obstetrician–gynecologists to refuse to accept a patient or decline to continue care that is within their scope of safe practice solely based on an arbitrary BMI cutoff or because the patient has obesity. Patients with obesity should be treated similarly to other patient populations that require additional care or have increased risks of adverse medical outcomes. For example, although pregnant patients with obesity require increased surveillance and have a higher-than-average rate of complications in pregnancy, their care is within the scope of practice of most obstetrician–gynecologists, and concerns related to increased risks of adverse events should not result in refusal to provide care.

Although obesity is not an indication for the transfer of routine obstetric or gynecologic care, consultation with or referral to physicians with expertise in obesity may be appropriate if the obstetrician–gynecologist cannot safely and effectively care for the patient because of a lack of specialized training, experience, or institutional resources. As with referrals for other indications, referrals for patients with obesity need to be made promptly and in a compassionate manner, and the practice should be applied uniformly and not based on personal bias or convenience. The medical reasons for such referrals should be clearly conveyed to the patient, and the referral should be undertaken in a way that does not stigmatize the patient. Whenever possible, continuity

of care should be maintained, and the referring obstetrician–gynecologist should continue to offer to provide the elements of care that can be performed safely. The referring obstetrician–gynecologist also may benefit from a close association with the consultant, learning about the aspects of care with which he or she is less experienced. This may be accomplished by the referring obstetrician–gynecologist acting as a co-surgeon or discussing care decisions or resources with the consultant to improve the referring health care provider's future practice options.

Physician Training

Many physicians report they lack the confidence, knowledge, or skill to incorporate evidence-based guidelines for obesity care into their practice (37). Beginning early in their training, it is important to provide medical trainees with the skills needed to treat patients with obesity effectively and to communicate openly and in an unbiased manner about obesity. It may be particularly important to use scientific evidence to debunk popular obesity-related myths for medical students (38). In a study of first-year medical students, an educational initiative that included standardized patients who were overweight or obese, along with targeted readings and facilitated discussion, had an immediate beneficial effect on stereotyping, empathy, and communication skills (39). Early and continuing medical education also should include instruction in how to assess, explore, and combat implicit weight bias.

Conclusion

Obesity is a medical condition that may be associated with bias among health care professionals, and this bias may result in disrespectful or inadequate care of patients with obesity. Obstetrician–gynecologists should be prepared to care for their patients with obesity in a nonjudgmental manner, being cognizant of the medical and societal implications of obesity. Thus, obstetrician–gynecologists should identify any personal bias and ensure that such bias does not interfere with just and compassionate clinical care of patients with obesity. Obstetrician–gynecologists should advocate in their clinical settings for the resources necessary to provide comprehensive care for patients with obesity. Patients with obesity should be transferred or referred for care in a uniform and unbiased fashion and only when obstetrician–gynecologists are unable to provide care safely and effectively themselves.

For More Information

The American College of Obstetricians and Gynecologists has identified additional resources on topics related to this document that may be helpful for ob-gyns, other health care providers, and patients. You may view these resources at: https://www.acog.org/Womens-Health/Obesity.

These resources are for information only and are not meant to be comprehensive. Referral to these resources does not imply the American College of Obstetricians and Gynecologists' endorsement of the organization, the organization's website, or the content of the resource. The resources may change without notice.

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