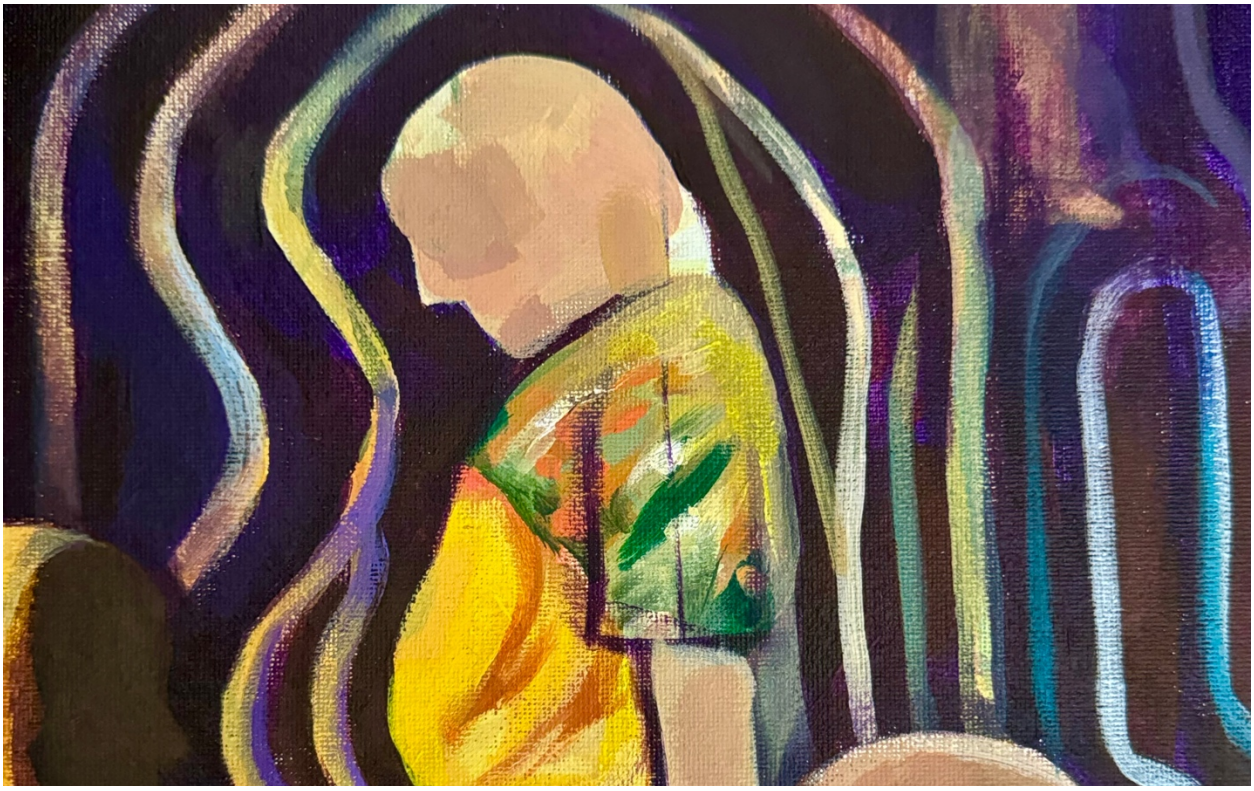

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Doubly Dangerous: Medical Students' Observations of Weight Bias in the Clinical Setting

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Weight bias is a form of discrimination that is pervasive in medical encounters yet often unacknowledged in medical education. In this essay, we reflect on the instances of weight bias witnessed during our clerkship year. Using vignettes gleaned from clinical encounters – an IVF patient with a Body Mass Index (BMI) of 44 accused of "doctor shopping"; a transgender man whose changing body size is emblematic of his transition; and a child receiving a striking visual lesson about fatty foods – we outline how weight bias violates the three fundamental principles of justice, autonomy, and non-maleficence. We propose a beneficent approach to BMI and weight bias that upholds these ethical principles in the clinic and medical classroom.

INTRODUCTION

Medical education emphasizes Body Mass Index (BMI) as a key indicator for health risks. Electronic medical records alert us to BMIs greater than 25 with bolded, red exclamation points. As medical students, we

learn that a BMI over 30 defines obesity, a disease we can treat with a menu of diets, medications, and surgeries. Yet, medical school curricula often overlook the link between BMI and weight bias, a pervasive form of discrimination in healthcare contexts. Countless patient narratives and international expert consensus state that weight bias exhibited by physicians damages health and undercuts human rights (1). This reality inspired the three of us (AMM, BB, MKV) to start a working group to address weight bias at our school.

As third year medical students at the end of our clerkship year, we reflect on how weight bias in clinical teaching spaces is doubly dangerous: it both undermines patient care and condones ongoing bias in future physicians. We present three cases in which the indiscriminate use of BMI came into direct conflict with the physician's responsibility to uphold three fundamental principles of medical ethics: justice, non-maleficence, and autonomy (2). These principles form an ethical framework emphasizing patient self-determination, welfare, harm prevention, and equitable healthcare access. By reimagining what a beneficent approach to addressing weight with patients and learners could look like, we argue that centering key ethical principles when caring for patients of diverse body sizes can help to reduce weight bias and promote patient-centered care.

JUSTICE

Case 1: "Kara is a 35-year old new patient, hoping to undergo a second egg retrieval for in vitro fertilization. When I asked why she transferred care from a local private practice, she cited dissatisfaction with her prior care, saying 'before I could ask what the lab work or hormone levels meant, the doctor was hurrying out of my room'". Dr. C, the attending, interrupted my presentation, scoffing, "That's not why she left the old practice. Her BMI is 44. Patients like her are always shopping for a new doc."

I (MKV) was on a reproductive endocrinology service, presenting Kara's case. My initial reaction to Dr. C's correction was to worry about my own performance. Did Dr. C think I was unable to elicit an accurate history? But another question worried me as well -- why were we assuming that Kara was being untruthful?

Several studies have shown that physicians spend less time in appointments with patients with elevated BMIs compared to patients with normal-range BMIs, raising concerns about inequitable allocation of healthcare resources on the basis of BMI (3-6). Patients whose BMI falls into the overweight or obese categories are also less likely to experience the same respect or emotional rapport with their physicians as their thinner peers (7, 8). A recent scoping review also suggested that when patients with elevated BMIs change doctors they usually do so because of differences in treatment, such as shorter visit times and stigmatization, rather than impulsiveness (9).

As medical students, we often adopt our instructors' heuristics and habits to enhance our clinical skills. As Dr. C corrected my history-taking, I was at risk of incorporating his weight bias (often an implicit bias) into my own practice. The incident illuminated that curbing the transmission of physician weight bias and addressing the resulting healthcare inequities necessitates raising awareness among both learners and educators. An awareness of weight bias in trainees, when integrated with a self-awareness of our own manner with patients, helps us to recognize and replace bias with empathy for patients' past healthcare experiences and curiosity about their goals while in our care.

AUTONOMY

Case 2: Taylor is a transgender man who

recently started gender-affirming treatment. At his annual visit, his primary care physician expressed concern about the increase in his BMI from 26 to 32 since starting testosterone. He counseled Taylor to reduce his caloric intake, prescribed phentermine-topiramate, and quickly moved on to see his next patient. As the door closed, Taylor's body language became tense. Sensing his frustration, I asked him how he had been feeling about his new body size. He shared that he sometimes worried about the health implications of his weight gain, while also feeling that it helped to align his appearance with his gender identity.

I (AMM) reflected that if we had elicited Taylor's experience at the outset, we could have seen past his BMI, validated his resilience, and helped him identify alternative ways to increase his body size. For example, working with a trainer could have centered his gender affirmation journey, helping him to build muscle mass while simultaneously optimizing his metabolism.

Taylor's narrative highlights that by reflexively defining BMI as a fixable problem, clinicians may default to paternalistic management rather than shared decision-making. This approach curtails autonomy, which hinges on patients having the chance to voice their preferences and make informed decisions. Concerningly, some medical ethics scholars believe that it is acceptable to limit the autonomy of patients with elevated BMIs, arguing that it is ethically justified insofar as it helps them lose weight (10). However, not only is there no evidence to show that paternalistic counseling helps patients lose weight,11–13 but an extensive body of research demonstrates that patients who feel disrespected (7), dehumanized (14,15), and stigmatized (6) by their physicians are less likely to adhere to their physician's advice (16,17), more likely to be lost to follow-up (18), and experience poorer long-term health outcomes (19).

The intersection of weight bias with other prejudices like sexism, racism, homophobia, transphobia, xenophobia and others amplifies the stigma experienced by marginalized patients once they enter a doctor-patient relationship (20,21). Taylor's experience shows how even subtle forms of weight bias encourage premature closure of the medical encounter, denying patients the opportunity to contextualize their attitudes towards food, exercise, and body image.

NON-MALEFICENCE

Case 3: A medical student, Rick (fictitious name to protect anonymity), shares excitedly about a "creative" intervention he learned for tackling obesity in the pediatrics population while seeing a 10-year-old boy with a BMI consistently at the 99th percentile. At the suggestion of his attending, Rick showed the child how many grams of fat are contained in potato chips, pizza, and cookies by measuring equivalent portions of lard into clear baggies. The patient was shocked to see his favorite foods transformed into fatty lumps and related this to his own body. Months later, the patient's mother joyfully updated the pediatrician that her son had lost 5 pounds. Rick expressed satisfaction that the intervention made a positive impact on the boy's health.

This story made me (BB) reflect on my own experiences at the pediatrician's office as an "obese" patient, which were punctuated by admonishments about my position on the growth chart and terse directives to eat less and exercise more. My repeated attempts to implement my doctor's guidance fueled patterns of obsessive food restriction, culminating in a diagnosis of anorexia which consumed my teenage years.

While such graphic efforts might seem fruitful in bringing about the desired goal of weight loss, clinicians often do not scrutinize the potential long-term harms of

this approach. There is a wide body of literature disproving the once-popular notion that shame is ethically justified if it motivates weight loss (10). Furthermore, creating associations between food and shame in children puts them at increased long-term risk for developing eating disorders (22, 23). Beyond eating disorders, weight bias in healthcare settings impacts patients' willingness to engage with care to avoid the discomfort of feeling stigmatized (9, 24), leading to withdrawal from care, delayed diagnoses and worse disease progression (8, 15).

The contrast between Rick's genuine belief that he had helped his patient and my own personal experience with my pediatrician emphasizes the insidious nature of weight bias. Without learning how to identify and combat weight bias, clinicians can unknowingly cause iatrogenic harm.

REFLECTIONS: A Note on Beneficence

As we reflect on the pervasive weight bias throughout our clerkship year, we hope to identify ways to provide more beneficent care for patients of all body sizes. The assumptions made about Kara's motivations for "doctor-shopping," and the ways biases can be transmitted to trainees motivate us to advocate for addressing weight bias in medical education. Taylor's story inspires us to learn about our patients' relationships with their bodies, irrespective of BMI. Rick's enthusiasm for the lard intervention reveals how even well-intentioned healthcare agents can cause harm by centering the benefit of weight loss without exploring the long-term consequences of inflicting shame on a patient.

We believe that teaching medical students about weight bias is essential to reduce its unforeseen ethical, emotional, and physical consequences. Medical trainees should learn evidence-based, weight-neutral clinical skills that empower patients to optimize their health, such as teaching mindful eating, promoting increased fruit consumption, and encouraging enjoyable physical activity (24-26). As future physicians, we will work with patients to understand the complexities of their health; in doing so, we have valuable opportunities to help patients cultivate healthier relationships with their bodies. Unchecked weight bias undercuts the healing potential of this privilege – and that is truly a shame.

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