Thinking About People-First Language: Weight Bias, Stigma, and Discrimination, and Women's Reproductive Health

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Language is powerful. As health care providers we use language to teach, to share knowledge, and to care for our patients. Our words and attitudes can also inflict harm if we are not careful, and for some of our patients this can have direct impact on the quality of their care. The issues around obesity are particularly sensitive.

RELEVANCE OF WEIGHT BIAS, STIGMA, AND DISCRIMINATION IN WOMEN'S HEALTH CARE

Women are disproportionately affected by weight discrimination (see the Table for definitions of weight bias, stigma, and discrimination[1]). Women with a body mass index of 30−35 kg/m^2 are three times more likely to report weight discrimination as compared with their male peers.[2] This phenomenon is compounded by even higher rates reported for visible ethnic groups (e.g., Blacks, Asians), as well as for sexual and gender minority groups.[2,3]

WEIGHT DISCRIMINATION IMPACT ON HEALTH CARE

The impact of obesity on medical outcomes is well known, as detailed in guidelines of the Society of Obstetricians and Gynaecologists of Canada.[4−6] However, we as clinicians are less aware of the concept that obesity stigma may be an independent determinant of poor birth outcome.[7]

As women's health providers, we need to be cognizant that our patients may have negative experiences related to our provision of care, from the sizes of the chairs in waiting areas to improperly sized medical equipment, difficulty with pregnancy and gynaecologic ultrasound image quality, and challenging pelvic examinations and Pap tests. Not surprisingly, labour and birth experiences, as well as gynaecologic procedures, provide challenges and sometimes frustrations to the care team because of the complexity around patient safety, positioning, fetal monitoring, and anaesthesia; in turn, those challenges and frustrations may be negatively perceived by our patients.

It is worth noting that we as providers of women's health care are also vulnerable to discrimination and being the subjects of stigma and bias. Providers perceived as overweight or obese may be subject to biased attitudes from patients, thereby creating a potential barrier to patient-provider trust and the likelihood of the patient following medical advice.[8] Thus all parties in the health care setting, including patients, families, and providers, may benefit from increased awareness of the bidirectional nature of weight stigma and weight bias.

PRACTICAL TIPS FOR ADDRESSING ISSUES OF WEIGHT BIAS, STIGMA, AND DISCRIMINATION IN YOUR PRACTICE

Language

People are not defined by their condition. Consider "a pregnant woman with obesity" rather than "an obese pregnant woman" in discussion and in writing. For more details on recommended language, visit the Obesity Action Coalition website.[9]

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Table. Definitions of weight bias, weight stigma, and weight discrimination

Term	Definition
Weight bias	Refers to negative attitudes towards others because of their weight
Weight stigma	Refers to stereotypes and labels we assign to people who have obesity
Weight discrimination	Refers to actions against people who have obesity that can cause social exclusion and inequities

Adapted from Obesity Canada.[1]

Waiting Rooms

The Obesity Action Coalition recommends providing seating without arm rests or supplying wider chairs to accommodate all sizes. Consider avoiding publications that promote an unhealthy body image or contain discriminatory images of the female body with overweight or obesity.[10]

Clinics

Consider weight scales with appropriate capacity. Record the blood pressure cuff size that suits your patient so that it can be used at subsequent visits and in the inpatient setting. Make a note of the vaginal speculum size that works best for your patient so it can be used at subsequent visits. Hand-held Doppler assessment of the fetal heart rate may not be feasible in some cases before 16–20 weeks, depending on maternal body habitus. It may be helpful to explain the limitations of the equipment and consider the use of transabdominal ultrasound to confirm the presence of a live fetus. Because obstetrical and gynaecologic ultrasound examinations have limitations related to body mass index, education of both the imaging staff and patients may help to reduce frustration and discomfort for all involved. For ultrasound units assessing an increasing number of patients with obesity, it may be helpful to review booking templates to ensure that providers are safeguarded from repetitive stress injuries.

Labour Wards and Inpatient Settings

Think about guidelines and protocols that will help make challenging care feel more standard for the patient, their family, and the entire health care team.

CLOSING THOUGHTS

We all need to be aware of our potential for creating and being at the receiving end of weight bias and discrimination in the health care setting. We should feel empowered to speak up respectfully when we hear colleagues, learners, patients, and their families use weight-negative language intentionally or unintentionally. As our understanding of weight bias, stigma, and discrimination evolves, we must also recognize that the terms our patients use may evolve as well. There is a movement among some women towards “reclaiming” the word “fat” in place of “obese,” and it will be helpful to ask our patients what terms they would prefer. Better communication and awareness of weight bias, stigma, and discrimination can help us and the health care system provide better, thoughtful care to all.

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