Ethical Issues in the Care of the Obese Woman

ABSTRACT: Rates of obesity in the United States have increased rapidly over the past several decades, and physicians should be prepared to care for obese patients in a nonjudgmental manner, being cognizant of the medical, social, and ethical implications of obesity. It is the responsibility of the physician to recognize the medical risks that are associated with obesity and to counsel the patient regarding these risks in an unbiased manner, respecting her autonomy and maintaining her dignity. Classifying obesity as a medical condition can serve to reduce bias toward obese patients and to change the approach toward the patient from one of blame to one of caring. It is unethical for physicians to refuse to accept a patient or decline to continue care that is within their scope of practice solely because the patient is obese. However, if physicians lack the resources necessary for the safe and effective care of the obese patient, consultation or referral or both are appropriate. Obesity education that focuses on the specific medical, cultural, and social issues of the obese woman should be incorporated into physician education at all levels.

As the prevalence of obesity has increased over the past several decades, Fellows have been faced with the challenges inherent in caring for obese patients. Fellows should be prepared to meet these challenges with compassion and without bias against the obese woman. In this Committee Opinion, the Committee on Ethics of the American College of Obstetricians and Gynecologists reviews ethical issues involved in the care of the obese woman and offers the following recommendations and conclusions:

• Physicians should be prepared to care for obese patients in a nonjudgmental manner, being cognizant of the medical, social, and ethical implications of obesity.
• Recommendations for weight loss should be based on medical considerations.
• An understanding that weight loss entails more than simply counseling a woman to eat less and exercise more and a willingness to learn about the particular causes of a patient’s obesity will assist physicians and other health care professionals working with them in providing effective care.
• Physicians can serve as advocates within their clinical settings for the necessary resources to provide the best possible care to obese women.
• It is unethical for physicians to refuse to accept a patient or decline to continue care that is within their scope of practice solely because the patient is obese. However, if physicians lack the resources necessary for the safe and effective care of the obese patient, consultation or referral or both are appropriate.
• Physicians should work to avoid bias in counseling regardless of their own body mass index status.
• Obesity education that focuses on the specific medical, cultural, and social issues of the obese woman should be incorporated into physician education at all levels.

Introduction

Obesity is defined as having a body mass index (BMI [calculated as weight in kilograms divided by height in meters squared]) of 30 or greater (1). Obesity can be further subdivided. Class I obesity is defined as a BMI of 30 to less than 35, class II obesity is a BMI of 35 to less than 40, and
class III obesity is a BMI of 40 or greater (2, 3). The class III subdivision of obesity does not differentiate among those with the most extreme levels of morbid obesity, BMIs in the 50s, 60s, and beyond 70. Rates of obesity in the United States have increased rapidly over the past several decades. At present, all 50 states and the District of Columbia have an obesity rate of more than 20%, and more than a dozen states have an obesity rate of greater than 30% (4). Overall, approximately 36% of adult women in the United States are obese; obesity rates have doubled between 1980 and 2004 (5). More recently, obesity rates appear to have peaked at a high prevalence (6).

Given these statistics, obstetrician–gynecologists will inevitably encounter obese patients in their practices. Physicians should be prepared to care for obese patients in a nonjudgmental manner, being cognizant of the medical, social, and ethical implications of obesity.

**Medical Risks of Obesity**

Although not all women who are obese will experience negative medical sequelae as a result of their obesity, obesity does significantly increase the risk of adverse medical outcomes throughout the life spectrum, particularly for women with class II or class III obesity (2). Such associated risks include higher rates of polycystic ovary syndrome, with prolonged anovulation resulting in higher rates of infertility and estrogen-related malignancies such as endometrial cancer. Obesity also is associated with higher rates of developing diabetes, as well as increased rates of surgical complications such as wound infections and thromboembolic events (7, 8).

Obese women who are pregnant face increased risks of gestational diabetes, hypertension, preeclampsia, cesarean delivery, and postpartum weight retention (9). The fetuses of obese pregnant women are at increased risk of prematurity, stillbirth, congenital anomalies, and, paradoxically, for both macrosomia and decreased birth weight (9, 10). Prenatal ultrasonographic evaluations are technically limited in the context of maternal morbid obesity. As a result, the rates for antenatal detection of fetal anomalies have been shown to be significantly decreased in women with a BMI of 30 or more when compared with women whose BMI falls within the recommended range (11). Once they are born, these children face increased risks of obesity and hypertension in adult life, supporting the findings that the intrauterine environment can affect the health of children (12–14). Additionally, all-cause mortality is increased in children born to obese mothers (15).

As part of well-woman and prenatal care, BMI should be calculated for all women. Women should be counseled on physical activity, and a dietary and nutritional assessment should be undertaken, including an assessment of both obesity and eating disorders (16). Physicians should familiarize themselves with the degree of risk that an elevated BMI confers on both morbidity and mortality and be prepared to discuss specific risks with their patients (2, 17). Physicians play an integral role in making recommendations to promote behavior change for women who are obese or at risk of obesity. Informed consent entails providing the patient with an accurate assessment of her risks when contemplating decisions such as undergoing surgery, deciding the route of delivery of a child, or choosing whether to embark on the treatment of infertility. In some cases, a recommendation for weight loss before undergoing surgery or attempting pregnancy may be warranted.

**Increased Resource Utilization in the Care of the Obese Woman**

At times, the care of the obese woman will require the physician 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 are often performed in more cost-effective outpatient surgical centers may need to be undertaken in hospitals because of increased anesthesia risks to obese patients, 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 regarding minimizing their increased risks. Perceived or actual risks of complications arising from the care of obese patients may lead to refusal to care for them based on fear of increasing professional liability or the additional time and resources that their care demands. Obese patients should not be viewed differently from other patient populations that require additional care or who have increased risks of adverse medical outcomes. For example, women of advanced maternal age or with medical comorbidities such as hypertension require increased surveillance, and their pregnancies are associated with a higher than average rate of complications. Despite this, their care is within the scope of practice of most obstetricians and concerns of increased risk of adverse events ought not to result in refusal to care for them.

**Counseling**

Recommendations for weight loss should be based on medical considerations. It is the responsibility of the physician to recognize the medical risks that are associated with obesity and to counsel the patient regarding these risks in an unbiased manner, respecting her autonomy and maintaining her dignity. The physician should avoid blaming the patient for her increased weight and integrate weight loss conversations into medical recommendations. Taking care not to overstate or understate the medical risks of obesity to a given patient when assessing her unique medical situation, the physician best performs counseling in an honest manner based on the woman’s...
individual needs. For some women who are overweight or mildly obese, but have no other comorbidities, weight loss may not have a significant effect on health. For others, weight loss may have a considerable effect on health. Counseling can address not just the absolute BMI, but the overall health of the patient, her understanding of the risks that go along with an increasing BMI, and her desire regarding weight management. A discussion of bariatric surgery will be appropriate in some cases (18).

Obese women may face barriers to optimal care. Awareness of these barriers will assist physicians in working toward eradicating them in their practices. Modern society often stigmatizes obesity (19). In many cases, the obese woman is blamed for overeating or not exercising enough. Such blame can come from her family, friends, peer groups, and complete strangers. The obese woman may blame herself for her weight. It is imperative that the physician recognize the social and economic determinants that may be at play in a woman’s weight status. An understanding that weight loss entails more than simply counseling a woman to eat less and exercise more and a willingness to learn about the particular causes of a patient’s obesity will assist physicians and other health care professionals working with them in providing effective care. Furthermore, there is a link between obesity and mental health disorders (20, 21). Referral to mental health professionals can be an important adjunct in the treatment of obesity when warranted.

In many instances, Western society and the media place value judgments on obesity as negative and thinness as positive. Obese women are often seen as “abnormal,” and their weight is seen as “bad.” This stigmatizes women whose bodies fall outside of a perceived norm (22). In actuality, weight is a continuum, and there is not a BMI level at which a woman crosses from being healthy to being unhealthy.

One way of destigmatizing obesity is by framing it as a medical problem (23). In 2013, the House of Delegates of the American Medical Association (AMA) approved by vote the policy that the AMA recognizes “obesity as a disease state with multiple pathophysiological aspects requiring a range of interventions to advance obesity treatment and prevention” (24). Defining obesity as a disease has advantages and disadvantages. Many women who are obese will not be unhealthy, although they may be at increased risk of becoming unhealthy over time and in certain situations such as during pregnancy or in the perioperative period. Classifying obesity as a medical condition can serve to reduce bias toward the obese woman and to change the approach toward the patient from one of blame to one of caring. Conversely, classifying obesity as a medical condition may result in a counterproductive acceptance of obesity and in a decreased willingness on the part of the physician to counsel regarding risks and to suggest weight loss. Also, patients may be too ready to accept their obesity as a medical issue that they have no control over, thus disempowering them to effect change.

Consultation and Referrals
In some cases, physicians may not be medically capable of caring for a particular obese woman or providing a portion of her care. When a physician is not able to provide safe and effective care to an obese patient, consultation or referral is appropriate. Options for consultation and referral include a single-visit consultation, continuing collaborative care, and transfer of primary clinical responsibilities (25). It may be appropriate to refer an obese woman to another health care provider for an element of care that a given physician is unable to provide, while the referring physician continues to care for the patient overall. Whenever possible, continuity of care is to be maintained. The referring physician may benefit from a close association with the consultant, learning about aspects of care with which they are less experienced. This may be accomplished by acting as a cosurgeon or discussing care decisions with the consultant. Being unable to provide one aspect of care to an obese patient should not prompt the clinician to decline providing other aspects of care that he or she is competent to deliver. Physicians can serve as advocates within their clinical settings for the necessary resources to provide the best possible care to obese women.

As with referrals for other indications, such referrals need to be made promptly and in a compassionate manner. In such cases, the patient should be referred to a clinician who has the skills, experience, and appropriate facilities needed to care for her. The medical reasons for such referrals should be clearly conveyed to the patient, and the referral should be undertaken with respect. Such referrals should be based on the ability of the physician to provide safe and effective care, and they should be applied uniformly. They should not be made based on personal bias or convenience.

It is unethical for a physician to refuse to accept a patient or decline to continue care that is within his or her scope of practice solely because the patient is obese. Refusing to provide care to all obese women as a blanket practice preference is unreasonable and unacceptable.

The Patient–Physician Relationship and Barriers to Good Medical Care
The principle of beneficence should be applied to the care of the obese woman. Efforts to promote her welfare and provide the best possible medical care should be undertaken. Being aware of the specific needs of the obese woman, in the context of the medical and social determinants that affect her, will assist the physician in this goal. At the same time, the physician should minimize harm to the obese patient, in accordance with the principle of nonmaleficence.

Another issue that arises when attempting to optimize the care of the obese woman is one of justice (26). Many obese women of lower socioeconomic status do not have access to healthy foods or an ability to exercise.
in a safe environment (8). These factors affect the prevalence of obesity, and physicians should take such social conditions into account when counseling women regarding their weight and providing education regarding approaches to address it. While incorporating strategies to prevent and treat obesity, physicians also should beware of adhering to specific weight thresholds, because by doing so, there is a risk that an entire category of slightly lower weight women who may have near equal risk will be ignored. Additionally, as obese patients use a higher percentage of health care resources, nonobese patients may bear an unjust burden of total health care costs. The best way of effecting change might be incorporating strategies for all patients to live healthier lives and maintain a normal weight, to the extent possible given limited resources.

Physicians should be aware of their own biases when caring for obese patients and should ensure that such biases do not interfere with the patient’s autonomy. In a 2001 review, the authors summarized a series of studies demonstrating that health care professionals are more likely to possess negative attitudes toward obese than nonobese patients (27). These include the belief that obese patients are “lazy, noncompliant, undisciplined, and lacking in willpower.” Physicians in another study reported that seeing obese patients was “a greater waste of their time” and that heavier patients were “more annoying” (28). Physicians also predicted that heavier patients would be less compliant than those with lower BMIs. A recent report indicates that physicians demonstrated less emotional rapport with overweight and obese patients, raising concerns that this may lead to a weakening of the patient–physician relationship and decrease the effectiveness of behavior change counseling (29). These negative biases extend even to physicians who specialize in treating obese patients (30). Physicians who dismiss the effectiveness of obesity prevention and treatment modalities undermine their ability to form a therapeutic relationship with the patient (31). Such negative attitudes place the patient–physician relationship at risk.

Another barrier to good patient care may actually be the BMI of the caring physician. Physicians who themselves are obese may be reluctant to discuss weight loss strategies with their patients. Conversely, physicians with a normal BMI more frequently reported weight loss discussions with their obese patients (32). Physicians should work to avoid bias in counseling regardless of their own BMI status.

Physicians may fear a backlash from patients whose obesity is part of their identity and who may not view their obesity as requiring intervention (23, 33). Such “women of size” may perceive weight-related suggestions as discriminatory and physicians making such recommendations as not “size friendly” and even paternalistic (26, 34). Such adversarial positions may compromise the patient–physician relationship. Physicians may decrease such negative reactions to their recommendations by clearly explaining the medical rationale for their advice in a nonconfrontational and factual manner. Some women may have considered the pros and cons of weight loss compared with maintaining their current lifestyle and decided that, for them, the risks of obesity are outweighed by the effort required to lose weight. Physicians can best serve their patients by remaining their advocates even when obese women choose not to engage in weight-loss strategies (35). Patients who feel that their health care providers are judging them based on their obesity may be reluctant to seek care, may delay or avoid scheduling preventive care appointments, and may be hesitant to contact their physicians for problems as they arise.

Still, physicians ought to feel free to express their opinions as educated health care providers regarding the risks of obesity and its potential comorbidities. A sense of balance is essential as physicians consider these issues in trying to guide patients to ensure that they are receiving appropriate and timely care. Education and counseling efforts, however, ultimately need to respect the patient’s autonomy to make decisions regarding her health care.

Some have argued that exercising social pressure as a preventive strategy by stigmatizing obesity may be the best way to contain the obesity epidemic because it expresses obesity as an abnormal state of being and a condition to be avoided (36). This can be likened to campaigns that stigmatized cigarette smoking in an attempt to both discourage smoking initiation and encourage smoking cessation. If elected, this strategy needs to be undertaken within a larger framework, recognizing that not all obese women have access to what are broadly seen as lifestyle choices such as access to healthy food choices and opportunities for regular exercise that would help them maintain a normal weight.

Others have suggested the integration of financial incentives to promote healthy behavior. These include lower insurance premiums for patients of normal weight, or incentive programs that would decrease health insurance costs for obese individuals who enroll in weight-loss programs (37, 38). Physicians must work to avoid stigmatizing their obese patients, while being cautious that avoidance of stigmatization does not lead to ennui in counseling patients regarding the medical risks of obesity and ways to mitigate these risks.

Conclusions

Given the changing demographics of body weight in the United States, Fellows must be prepared to care for the obstetric and gynecologic needs of their obese patients. Obesity education that focuses on the specific medical, cultural, and social issues of the obese woman should be incorporated into physician education at all levels (39). Such training should provide physicians with the tools necessary not only to care for the obese patient, but also to feel comfortable discussing obesity and its associated health risks with her in an ethical and unbiased manner. Physicians may benefit from a multidisciplinary
team approach with internists, surgeons, nutritionists, dieticians, mental health professionals, and community-based programs in order to help their patients achieve weight loss.

If physicians place value judgments on obesity and see this condition as different from other chronic health conditions or determinants, they are at risk of treating their obese patients with bias. If, however, obesity is seen as a modifiable risk factor, in the mold of hypertension, hypercholesterolemia, or smoking, physicians will be better able to objectively counsel and care for their obese patients in an ethical and effective manner.

References


