COMMENTARY

Scaling Back on Weight as a Measure of Patient Health

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Back when he was a graduate student, my friend, Dr Travis Saunders, was a ridiculously active runner and cyclist who primarily ate home-cooked meals made from whole ingredients. Despite living a healthier lifestyle than what I'd venture 99.9% of us are, he was told at his yearly physical to "watch his weight," as he was approaching a BMI of 25 (the start of the medical descriptor "overweight").

In a similar interaction, a patient of mine told me about how she had lost more than 100 lb by maintaining a lifestyle of high physical activity and eating an unabashedly healthful diet. But after being weighed by her new family physician, she was quickly lectured about the risks of obesity and told that she ought to try exercising more and eating healthier.

Meanwhile, how many thin patients do you think have never had their physician explore the fact that their diets are made up primarily of ultra-processed and fast foods, and that their exercise is limited to changing the channel on the remote control or scrolling on their phones?

What Does a Scale Measure?

The problem in all of the cases above tracks back to faulty scale use, and perhaps it isn't all that surprising. When I was a medical student in the 1990s, I wasn't taught how to use a scale, and I'm betting that the same is true for most medical students today. Don't get me wrong; it's not that I think scales are complicated pieces of equipment, but after exclusively practicing obesity medicine for the past 15 years, I do think that their proper use is worth discussing.

Scales do measure the gravitational pull of Earth at a given moment in time. Scales don't measure the presence or absence of health, nor do they measure lifestyle or effort. And for patients, it's useful to note that scales don't measure happiness, success, or self-worth, either.

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Although weight is undeniably a risk factor for a host of medical comorbidities, especially at its extremes, it's not a guarantee that any of them will occur. And so the use of a scale to infer the presence or absence of health ignores the actual person standing on the scale.

Similarly, scales don't measure lifestyle. There are scads of patients with obesity doing all of those good things—exercising regularly, getting enough sleep, not smoking, cooking with whole ingredients, etc. Similarly, plenty of thin patients' lives are spent living on junk food, smoking, drinking to excess, and spending all of their off-hours binge-watching television and being inactive.

Relying on scales to measure things that they can't leads physicians to make assumptions that undermine the care and understanding of all of their patients, and is no doubt reflective of weight bias. This, in turn, has been shown to affect the quality of care for patients with obesity.[1]

By way of their interactions with healthcare professionals who judge them by their weight, patients with obesity may be less likely to seek medical attention, and their physicians may be less likely to thoroughly investigate differential diagnoses, communicate information, or consider treatment options beyond some variation of "eat less, move more"—advice that is about as useful and actionable as telling patients with depression to "just cheer up," or your accountant telling you to "buy low, sell high."

Lifestyle and Privilege

Plainly put, weight should not be the factor that determines whether you discuss lifestyle factors with your patients. Lifestyle is to be discussed—using open-ended, unassuming questions—with all patients, as it affects health regardless of a person's weight while simultaneously not determining it.

In these discussions, it's also crucial to consider that intentional, perpetual, and unremitting behavior change in the name of health or the treatment/prevention of a noncommunicable disease requires a tremendous amount of privilege that a majority of people simply don't possess. For many people, time might be better spent working long hours to put food on the table and pay rent, or on caregiving responsibilities.

We definitely don't have the same 24 hours, and the inconvenient truth of healthy living is that it involves significant time and effort. Chronic pain, disability, poor mental health, or fatigue may make regular cooking and exercise unattainable luxuries in the face of very real and chronic challenges. The simple reality is that many patients' lives are or have been filled with hardships that knock healthy-living considerations way down the rungs of worthwhile pursuits.

I'll go further and say that even for those with all the privilege in the world, there is no rule that states that not exercising makes that patient any less worthy of a physician's respect and caring attention.

And here I'll point out that the vast majority of noncommunicable diseases are treatable or preventable by way of lifestyle changes, yet for the most part, the only one for which patients are judged if they don't succeed or try to tackle it on their own is obesity.

Our job as clinicians is to inform and advise our patients to the best of our ability of the various treatments—including lifestyle—that might improve or protect their health. What we should never do, however, is judge them on the basis of whether they follow our advice.

Medicine should never be about blame, and perhaps reflecting on what scales do and don't measure, as well as recognizing the reality that obesity is not unique among noncommunicable diseases that result from lifestyle factors, will help keep that important truth in sharper focus.

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References

1. Phelan SM, Burgess DJ, Yeazel MW, Hellerstedt WL, Griffin JM, van Ryn M. Impact of weight bias and stigma on quality of care and outcomes for patients with obesity. Obes Rev. 2015;16:319-326. Source

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