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INFORMING PATIENTS ABOUT THE RISKS OF OVERWEIGHT AND OBESITY - ETHICAL CONSIDERATIONS

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Abstract

Obesity is one of the most important public health issues in the modern world. It is known as risk factor for many chronic non-communicable diseases such as type 2 diabetes, hypertension, coronary heart disease, various cancers, diseases of the musculoskeletal system, mental illness, etc. It is also chronic disease itself. A wide range of medical professionals are involved in the treatment and control of overweight and obesity - general practitioners, endocrinologists, nutritionists, psychologists, health care professionals, bariatric surgeons, pediatricians, etc. Communication plays an essential role in both prevention and treatment of obesity. In this paper we review the literature to identify the causes and difficulties for physicians to inform their patients about the risk of overweight.

Medical professionals with different specialties often pay attention to the underlying disease and avoid addressing patient's overweight as significant risk factor. Bad attitudes towards people with obesity are well known. In Durrer and Schutz's model for managing overweight and obesity, communication (through a motivational interview) and patient education are central. However, in Bulgaria not much attention is paid to medical communication. We emphasize the need to develop additional recommendations for ethical attitude towards obese patients that could be helpful for medical staff to communicate risks of obesity without promoting stigma.

Patient centered care involves understanding the needs and values of the patient, which could be achieved through the application of various communication techniques. Continuing education in obesity management and medical communication is important in order to improve medical results and patients' satisfaction.

***Key words**: Communication, Obesity, Risk factors, Healthcare professionals.*

1. Introduction

The World Health Organization (WHO) identifies obesity as one of the most serious threats to health in the 21st century. The number of overweight and obese people is growing worldwide. Epidemiological data clearly show obesity is reaching the size of a pandemic and is one of the most important public health issues. According to WHO data, obesity is one of the leading preventable causes of death in the world [1]. In 2016 more than 1.9 billion adults worldwide were overweight. Out of those, over 650 million were obese. The prognosis is that 573 million people will suffer from this chronic disease by 2030 [2]. According to the National Center of Public Health and Analyses in Bulgaria, overweight and obesity are a serious problem, with 5% of children under 4 overweight and with this figure reaching 30 in school-goers. Between 12% and 15% of children are obese [3, 4].

The health consequences of being overweight and obese are numerous. Obesity increases the risk of some chronic non-communicable diseases: cardiovascular disease (mainly ischaemic heart disease and stroke), type 2 diabetes, osteoarthritis, and some cancers (of the endometrium, ovaries, breast, prostate, liver, gallbladder, kidney and colon) [5, 6]. Those are the direct physical health consequences, but the various psychological, emotional and social effects of being overweight cannot be ignored either.

Our aim was to review the literature to identify the causes and difficulties for physicians to inform their patients about the risk of overweight.

2. Ethical issues in working with overweight and obese patients

2.1 Main ethical principles in obesity control and management

The risk factors for obesity are numerous, so the approaches to dealing with it must be comprehensive. The UK programme "Tackling Obesity: A Framework for Action" distinguishes between "upstream", "central" and "downstream" obesity prevention policies. Upstream policies are aimed at the whole society, central policies target individual behaviour and downstream ones deal with the treatment of people already affected [7].

Nowadays, the concept of personal responsibility for health, based on one of the fundamental principles in medical ethics, namely respect for autonomy, finds an important place in the doctor-patient relationship. In medical practice, the patient is an autonomous person with their own value system and religious beliefs, who is capable of comprehending the information received, making decisions and bearing responsibility for them. Lifestyle decisions are directly related to being overweight and its health consequences. The choice of a certain lifestyle, however, does not only result from personal factors but also a number of environmental ones - ecological and social. For example, the social environment (including family, workplace, etc.) and socio-economic factors are powerful externalities for choosing an unhealthy lifestyle, i.e. having a poor diet, sedentary life and bad habits. The authors discuss the problem that individuals do not always consider "wellbeing" synonymous with "good health" [8, 9]. For example, it is impossible to objectively judge whether a vegetarian or athlete on a special diet has a better quality of life than a smoker who prefers fast food. It is precisely the subjectivity in assessing quality of life that precludes blaming an overweight person for their condition (blaming the victim) [10]. This is why governments are taking paternalistic action to protect individual health. The imposition of fees and taxes on harmful foods (containing rich in sugar, salt, saturated fat, etc.) violates individual freedom of choice, but it does so for the good of the individual. By their nature, paternalistic actions are well-intentioned and based on the principle of benevolence. If personal responsibility is considered the ideal, it is wrong for the state to violate individual autonomy and freedom in an authoritarian manner. Many authors support the role of the state in health education and awareness and in banning advertising and marketing of certain foods, which is supposed to lead to reduced consumption by society [8, 10, 11, and 12].

A review published in 2015, [13], showed that even nutrition professionals tend to stigmatize obese persons. This is not only related to negative outcomes like depression, but also avoidance of medical consultation and prophylaxis. Prejudice and stigma towards people with obesity are associated with:

- ✓ Poor body image and dissatisfaction with appearance;
- ✓ Poor self-esteem and lack of confidence;
- ✓ Feelings of uselessness and loneliness;
- ✓ Suicidal thoughts and actions;
- ✓ Depression, anxiety and other psychological disorders;
- ✓ Maladaptive eating patterns;
- ✓ Avoidance of physical activity;
- ✓ Stress-related disorders;
- ✓ Avoidance of medical care.

Another fundamental principle associated with obesity control is the principle of justice. It says all people should be treated equally. As individuals with obesity are considered high-risk groups, redirecting attention and public resources to them runs counter to the concept of equality [8, 14].

Some authors suggest the stigmatisation approach as an alternative to lifestyle change for those groups. They believe the stigma can be justified because it will encourage behavioural change. Vartanian and Syith [15], examined the ethical acceptability of "stigmatising the obese". This approach is based on two hypotheses:

- Obesity depends on self-control;
- Stigmatising obese individuals will motivate them to change their lifestyle.

Empirical data, as the authors note, do not support those hypotheses because they ignore the wide range of bio-psycho-social factors for overweight. Initiatives based on this approach are also at odds with the oldest known principle in medical ethics: first, do no harm [16, 17].

Stigma and discrimination against obese people are widespread and have significant consequences for their mental and physical health. Puhl and Heuer [18], also found that, in regards to public health, the stigmatisation of obese people jeopardised health, generated health inequalities and hindered other effective methods of intervention. Therefore, stigma can also be seen as a problem in social fairness. At the same time, fairness places ethical restrictions on the patient's freedom to claim limited medical resources.

2.2 Medical communication and its role in overweight and obesity management

It has long been known that communication skills are needed in patient care, and not only to take a medical history, but also to build trust in the communication process [19]. This includes understanding the patient's point of view on their condition, identifying their desires, goals and motivation to deal with the disease,

and their specific expectations of the doctor and the medical team [20, 21]. Although the importance of medical communication is well known, there is currently no organisation, practice and traditions in clinical communication in Bulgaria. Communication methods and techniques are of particular importance in general medical practice. This is because, as Ivanov and Kirov [22] found, they are used for relatively simple purposes, but have a great potential for obtaining and imparting huge amounts of factual, meaningful and emotional information from the patient to the doctor and vice versa. In addition to the exchange of information, medical communication can directly impact on the patient.

Empathy can be expressed by verbalising feelings and showing respect for the patient. Both the preliminary attitudes and preferences and the subsequent emotional response have to be evaluated. Shared decision-making involves discussing treatment options. Shared decision-making is defined as "an approach where clinicians and patients discuss the best available evidence when faced with the task of making a decision. In this relationship model, patients receive support in considering the options and making informed choices" [23].
The concept of shared decision-making has long been known, but the skills of doctors in using this approach are still being discussed.

Elwyn *et al.*, [23] proposed a three-step model for shared decision-making in clinical practice that is easy and convenient to use. The steps include:
1. Providing an opportunity to make a choice;
2. Describing the options to choose from;
3. Helping the patient analyse their preferences and make a decision.

Patient-centred care involves understanding the patient's needs and values, which could be achieved through various communication techniques. Addressing sensitive issues, such as being overweight, requires empathy and a lack of stigma and discrimination.

Risks are most often communicated to overweight and obese patients directly, but group discussions and brochures can also be organised [22].

2.3 Difficulties doctors face in communicating risk

The difficulties medical professionals face with respect to treating their patients' overweight have been studied. Some of the difficulties identified from GPs are the following: lack of time, lack of resources, lack of sufficient knowledge and skills in treatment and follow-up. In a large-scale survey, 72% of GPs surveyed said they had not been trained to deal with weight problems. There is still a lack of research into the ethical aspects of working with obese patients [24].

A study by Warder *et al.*, [25], shows the different position of medical professionals regarding the allocation of responsibilities and the goals of risk communication. The authors recommend that the differences be overcome by developing a conceptual framework with the participation of health communication specialists, which will benefit all stakeholders - medical teams and overweight patients.

The Rules of Good Medical Practice of Bulgarian GPs state that if they are to effectively communicate with patients, GPs must impart information comprehensively and be "polite, caring and honest" in order to create trust and partnership [26].

The Rules of Good Medical Practice of Bulgarian GPs set out some basic principles, including: "good communication skills and dignified treatment of patients." According to those rules, a doctor must treat patients with the necessary "attention and respect"; "listen and respect the position of patients."

2.4 Recommendations for ethical attitude

A wide range of medical professionals are involved in the treatment of overweight and obesity - general practitioners, endocrinologists, nutritionists and dieticians, psychologists, healthcare professionals, bariatric surgeons, paediatricians, etc. The analysis of many documents and recommendations for ethical treatment helped to formulate guidelines for ethical communication with overweight and obese patients that should be disseminated among doctors and other healthcare professionals.

Communication with an overweight/obese patient should be based on the following key points:

<u>- Partnership model in the Patient - Physician Relationship</u>

The concept of personal responsibility for health is well known in modern literature [12]. The patient's motivation is key to obtaining their compliance and achieving good medical results. The patient's willingness to change in the long term can be assessed through a motivational interview. Partnership is a good model of the doctor-patient relationship in patients with chronic non-communicable diseases, especially in general practice, where the family doctor is well acquainted with the patient and their environment. Specific recommendations for consulting an obese patient include:
• Greet the patient with empathy and without any negative judgments or bias;
• Keep in mind that the patient has been chronically

exposed to negative experiences when communicating with healthcare professionals about their excess weight;
• Recognise the multifactorial aetiology of the disease (individual and external factors);
• Take care not to use inappropriate or offensive words to maintain a positive and constructive relationship with the patient;
• Ask the patient if they are ready to talk about their body weight, having already broached the topic of obesity, especially if the patient has not come to the office for this particular problem;
• It is semantically important to talk about a patient "with obesity" and not an "obese" or "fat" patient, as this will be considered less stigmatising for the patient. It is also preferable to talk about "weight" and "body mass index" when addressing the problem, rather than "obesity" [27, 28].

There are two arguments that physicians usually use about their passive attitude towards patients with obesity – their inability to motivate the patient and the frequency of relapses after weight loss [29]. Motivational interviewing is a very effective communication technique that is non-judgmental and aims to use discussion to enhance the patient's own motivation and encourage them to participate in behavioural change. Motivation is extremely important for achieving long-term results and avoiding the yo-yo effect. Both the patient's diet and physical activity and the issue's psychological aspects have to be discussed, with the potential need for pharmacotherapy and bariatric surgery also noted. Empathy is a mandatory element. The positives and negatives of behavioural change in each patient have to be evaluated and graded according to their perceptions [20].

- Avoidance of Stigma and Discrimination

Stigmatisation is a common phenomenon that exacerbates eating disorders, increases obesity and depression, and has other negative consequences. Studies show it is unfortunately also found among GPs, nutritionists and paediatricians. A study of medical students shows that obese patients are often subjected to negative attitudes and humiliating jokes by fellow students (63%), healthcare professionals and (65%) and teachers (40%). The doctor can express support to the patient using non-verbal and verbal signals and means - gestures, hand or head movements, expressions such as: "this should not bother you", etc. [8, 30].

- Addressing psychological aspects, including the establishment of social support groups. Improving self-esteem and quality of life

Obesity has numerous causes and its psychological aspects should not be ignored. Obesity can be a form of addiction, which is why there are specialised mutual support groups around the world, such as Compulsive Eaters Anonymous. Referral to a specialist can provide a comprehensive picture of the problem [28].

- Involvement of a multidisciplinary team

It is recommended that the physician work together with a nutritionist, psychologist or psychiatrist, nurse, and the patient's family. The combination of a personalised diet, physical activity, behavioural programme and treatment of comorbidities can be made possible through the joint efforts of a multidisciplinary team.

- Good personal example by medical professionals

Medical professionals with obesity are themselves vulnerable to negative attitudes from patients. An overweight doctor can negatively affect the patient's perceptions, lowering trust and cooperation in treatment. There are initiatives worldwide aimed at increasing people's physical activity by following the example set by family doctors. "Walk with Your Doc" is a great example of a simple programme that encourages regular exercise in both physicians and patients and allows physicians to serve as health role models in their community [12, 31].

3. Conclusions

- Patient centered care involves understanding the needs and values of the patient, which could be achieved through the application of various communication techniques. Continuing education in obesity management and medical communication is important in order to improve medical results and patients' satisfaction.
- Team work is also prerequisite in the control of such important public health issue. We emphasize the need to develop additional recommendations for ethical attitude towards patients with obesity that could be helpful for medical staff.
- Health communication experts bring unique skills that help health care providers communicate risks of obesity without promoting stigma.

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