Weight and health in CBL cases

There is a long history of medicine supporting weight normativity in both clinical and research settings. Weight normativity is the idea that there is a weight that a person's body "should" be (Tylka et al. 2014). Weight inclusivity is the idea that human bodies come in a range of sizes and weights and that size and weight can be correlated with health but not causally linked. According to weight inclusivity, we should emphasize non-weight based markers of health and well-being.

Given extensive evidence that weight loss is an unachievable clinical goal for most patients, and weight cycling and weight stigma both cause adverse health outcomes (Tylka et al. 2014), weight inclusive approaches are preferred to weight normative approaches.

Weight inclusive approaches include the "health at any size" approach, which supports people in being physically active and eating well without focusing on weight loss, and a stronger critique of "healthism," I.e. accepting that medically defined "health" is not the only or most important goal of a good life.

The fundamental ethical principle of unconditional respect for persons whatever their weight and body composition, and the ethical imperatives to "do no harm" and provide the same standard of medical care for persons whatever their weight, are the foundation of any approach to weight in healthcare.

The language that we use to describe body size and weight is heavily stigmatizing. Among advocates for weight inclusivity, the preferred language is contested (as it is in other areas of anti-oppressive practice) (Nutter et al. 2016). Some advocate for person-first approaches (people living in larger bodies, for example, or people with upper-range weight), centering the person rather than a particular condition, while others argue for identity-first approaches that use "fat" as a neutral, factual descriptor the same way we might use hair colour or height (see the National Association for Fat Acceptance). Some patients prefer terms such as "big", "solid", "curvy", or "fluffy" (a reference to stand-up comedian Gabriel Jesús Iglesias), and research on patient preferences indicates that "weight" or "BMI" are favoured over "overweight" or "obese".

As the harms of weight stigma are increasingly recognized in medicine (Rubino 2020), medicine is also re-examining the BMI and its role in patient care. The BMI was invented by a eugenicist anthropologist in the 19th century and adopted by insurance companies in the early 20th century; the WHO and other health researchers adopted it and tried to improve its scientific validity, but it is now recognized that it is not adequately predictive of individual patient outcomes. The Canadian Obesity Network no longer recommends that it be used to guide clinical care (Wharton et al. 2020).

The Edmonton Obesity Staging tool is a better tool to direct individual patient care as needed. In many other areas of medical practice, such as anesthesiology, the BMI or weight/height measures may be necessary to ensure safe patient care. Unexplained, rapid weight loss or gain remain important clinical signs for serious underlying medical conditions, and identifying and managing these conditions requires discussion and measurement of weight with patients. Explaining to patients the need for measuring weight in specific instances is important for a respectful and trauma-informed approach to weight in clinical practice.

In our diversified CBL cases, the usual approach to anti-oppressive work is to name all dimensions of diversity, so that background assumptions are brought into the foreground and challenged. In order to

challenge weight normativity, however, we need to represent that it is not always necessary to weigh patients or provide a BMI, and we need to portray scientific and social controversies around BMI. So weight is not portrayed in a single way in cases.

When weight is portrayed in cases, the following approaches are appropriate:

- **Destigmatize weight**: use factual rather than evaluative descriptions of weight.
    - Keep the discussion open where stigmatizing language persists: e.g. the term "obesity" is still prevalent in medical use and formally defined in terms of BMI, but there is a valid viewpoint that says the term itself stigmatizes weight, and the BMI on which it is based is being re-evaluated.
    - Discuss structural and systems barriers to providing the same respectful and equal care to patients of any weight (e.g. equipment size; provider bias).
- **Challenge the medicalization of weight; interrupt biases in clinical reasoning.**
    - Do not default to counselling on lifestyle and weight loss due to visual impression or the patient's recorded weight/BMI.
    - Do not default to weight as the cause of the patient's symptoms or condition.
- **Don't assume that weight or BMI always correlate with metabolic health or are good individual predictors of health outcomes.** People whose metabolic health is compromised may also fit the medical definition of "normal" weight.
- **Develop clinical skills for patients of different body sizes and shapes:** taking weight routinely into account in clinical practice when appropriate (adjusting doses, procuring inclusive equipment).
    - When you need to know weight or BMI in order to adapt and provide safe care, ask permission and explain.
    - Patients and clinicians who identify with the fat acceptance movement may ask or expect **not** to be routinely weighed in clinical care.
- The BMI is not the only measure of weight or adiposity used in cases, and its limitations should be acknowledged where it is used.

Weight has often been represented as being subject to individual control, but a strong evidence base demonstrates that this is not the case. Efforts to classify obesity as a chronic disease were driven, in part, by a desire to reduce stigma for people whose weights are in the upper range by moving from individual responsibility to a disease state that requires medical management. Fat acceptance advocates, however, point out both that (a) this frames individuals with larger bodies and/or upper-range weights as inherently "diseased" or pathological, and (b) fat people should be treated with justice, respect, and empathy regardless of their health status, shape, and/or size (Bacon & Severson, 2019).

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