A 50-SOMETHING PRIMARY CARE PHYSICIAN, mother, wife, and woman of Eastern European descent who loves to cook and eat, I share on many levels the growing concern about overweight in this country and beyond. While many refer to this immense public health problem as the “obesity epidemic,” I object to that word—obesity—especially when used to describe individual patients. Calling patients obese defeats many of our aspirations as practitioners and may even sabotage the alliance we hope to establish as we take on healthy eating and living.

While some would argue that obesity merely describes a body mass index of 30 or above, the term also conveys judgment, disdain, and bias. It is not so different from “fat,” a label that can brand children among peers, not to mention internally, for years. My patients and acquaintances who battle weight are well aware of their foe and have struggled with any number of diets and other weight-loss fads. Countless visual reminders of how they deviate from media “norms” add to their daily despair, augmented by internal scoldings. Every day I hear about these concerns, not only from patients who meet criteria for overweight, but also from those who do not but have come to think of themselves as such because of media images and societal messages. It is the very rare patient who is content with her or his size. Patients frequently crash diet for several days before their annual physical examination, so concerned are they about what the scale might read or, worse, what the doctor might say about that dread number. Many are sufficiently distressed about their weight that the last thing they need is one more pejorative comment. They have already perfected such remarks chapter and verse.

I am in no way suggesting that patients don’t need help with the devilish and daunting challenge of excess weight and its many health complications. Rather, I wonder how we might help them climb out from under the negative messages and encounter hope and practical advice when they consult us. Our teaching should include information about body mass index, nutrition, exercise, emotional eating, personal goals, and so forth. But the word obese, in my opinion anyway, does not belong in the discussion.

In spite of our best efforts to create an informative and encouraging interaction during a visit, that word obese can still surface. It may show up in the problem list and medical summary handed to patients as part of meaningful use, or it may be linked to laboratory testing. 278.00 Obesity, Not Otherwise Specified is a diagnosis that most insurance plans will accept to cover a patient’s lipid panel and glucose testing, for example.

A colleague related the story of a patient who stormed back into the office after a blood draw following an appointment. Not only was she insulted that her physician had described her as “obese” on the laboratory requisition, but she asked with horror why no one had bothered to tell her she weighed 278.00 pounds! It was easy to straighten out the misunderstanding about the ICD-9 diagnosis code number but considerably harder to soothe the sting of knowing her physician considers her obese.

As we strive to educate and motivate our patients toward healthier living and offer them greater access to their own records through HIPAA, meaningful use, and patient portals in electronic medical records, we practitioners need to think carefully about how we express ourselves. We have worked hard to shed terminology like “the gallbladder in room 5” or “the train wreck in bed 8” in favor of language that is more respectful of patients and families. A single medical record that is accessible to both caregivers and patients challenges us to communicate in language that is clear and accurate but free of judgment and bias.

And yet even as we embark on this daunting task, we are under intense pressure from the electronic medical record, the anticipation of ICD-10, and countless nonmedical forces to label and number our patients in order to meet criteria for documentation, billing, and quality improvement. Real patients and problems seldom conform neatly to the language and numbers of systems like ICD-9. “278.00 Obesity, Not Otherwise Specified,” for instance, doesn’t distinguish between the couch potato who eats abominably and the solid teen who follows a healthy diet and is a three-season athlete.

Not long ago, my mother-in-law, age 77, fell on a broken sidewalk and bruised the knee she’d had replaced five years ago. When it became increasingly swollen and ecchymotic, her primary care physician referred her to an orthopedist. She later received a copy of his electronic note, which began, “The patient is a 77-year-old obese female,” a description she found offensive, not surprisingly. She was also bothered by the treatment plan in which the physician documented an extensive set of instructions he claimed to have reviewed with her but which she swears he did not relay either verbally or on paper (but that is a separate issue for another day).

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A Piece of My Mind Section Editor: Roxanne K. Young, Associate Senior Editor.
My mother-in-law is not shy about acknowledging those 10 to 30 pounds with which she has done battle over many years. But if asked to summarize her I’d strive for a fuller picture noting, for instance, “The patient is a 77-year-old adoring mother of four and grandmother of eight, retired third grade teacher, committed walker, talented birdwatcher, avid reader, and accomplished watercolorist who remains engaged in all these activities even as she and her husband (an 80-year-old retired dentist, devoted father and grandfather, voracious reader, ardent outdoorsman, self-educated financial whiz, and gifted teacher) are soldiering through Parkinson disease.” Imagine if we described, or even knew, our patients this well. Such information conveys a sense of curiosity and respect for the human beings whose medical problems we are tackling. Obese reduces them to a single, disparaging label. Summations like “278.00” and “obese” parse our patients into impersonal and judgmental categories, discouraging us from looking for their richer stories and histories, which so often complement our understanding of their conditions and treatments, as in the case of my mother-in-law.

The imperative to label and number is a constant in current medical practice. Naturally, we physicians can explain the system of diagnoses and ICD-9 codes to our patients. And the shock value of being called “obese” might even jolt the rare patient in the direction of healthy change. More often, however, I fear such terms linger as judgmental stamps, not only in the memories of our patients but also on the immortal pages of their records. They dilute the more collaborative, constructive, and encouraging messages we hope to send home with our patients, leaving instead a sense of self-defeat and the assumption that their physician doesn’t really believe they have what it takes to make healthy changes.

So many dehumanizing trends are seeping into our profession. We need to remember that people skills directly affect clinical outcomes. Human qualities like intuition, warmth, and emotional intelligence are profoundly important to effective communication and successful care. It behooves us to ally with our patients in order to speak out against the pervasive labels and numbers that lull administrators and legislators into a false sense that they can evaluate and track true quality and success using such limited parameters.

It is equally important to consider how we describe patients during visits and in records. The focus should remain on knowing our patients and their problems in the full context of daily living rather than pigeonholing them into drop-down phrases and diagnostic codes like 278.00 Obesity, Not Otherwise Specified. Imagine a diagnostic system built on composite knowledge of a patient’s unique clinical situation, including information about age, experience, responsibilities, motivation, and previous health challenges and successes. How creative our workdays would become.

No doubt some of you think I am dreaming. And to that I respond that many other groups currently dream and scheme on our behalf. What about a little input from the trenches? Let’s consider taking on the epidemic of overweight by building up our patients and giving them the confidence to cast off labels, whether self-imposed, ingrained by the media, or tattooed on by our profession. In placing the emphasis on our connection with patients and confidence in them, perhaps we can send them home with a greater belief in their own healing powers, not to mention our own.

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