

Language Matters: Obesity



Obesity UK is the leading charity dedicated to supporting people living with obesity.

With over 40,000 members, we hear on a daily basis how badly people living with obesity are spoken to and treated, and this is not okay.



“We are honoured to be launching the Language Matters for Obesity; and have enjoyed working with an esteemed group of people to create this document.”

Sarah Le Brocq, Director Obesity UK

“Language matters...”

We live in interesting times, encapsulated by the wide array of views society holds on many issues and topics, whether it be the environment, sports, politics or indeed health. The debate regarding the status of obesity as a disease is one of the most polarising in modern medicine. There are those that cite genetic, physiological and neurohormonal differences as evidence that it should be regarded as a disease, whereas those who would suggest the rise in obesity is a result of environmental shift towards convenience, socio-economic deprivation and the ready availability of processed high calorie food. This document does not attempt to address, this, rather tackle a far more immediate problem.

Every day we choose words that have a profound effect on other people. Language is a powerful tool, through which we communicate our hopes, our feelings, and the vicissitudes of life. Words have great potential to help, or to harm and, as clinicians, we know the strong value of good communication in our day-to-day practice.

Whilst the science and physiology, is complex, and we are always discovering new things about obesity, what we do know for sure is the stigma people living with obesity experience every day. Complex science is often distilled a simplistic narrative... “if only you ate less”. Clinicians, interacting one-to-one with their patients, have a clear opportunity to ensure that their conversations do not inadvertently contribute to this existing stigma. They can instead choose language that is inclusive, and supportive.

In 2018, the NHS England Language Matters: Diabetes document brought together healthcare professionals and people living with diabetes in order to outline appropriate terminology for people living with that long-term condition. This has been well received by people living with diabetes and healthcare workers alike.

Based on the success of this document, Professor Partha Kar, who had led in the development of the Language Matters Diabetes document, gathered stakeholders notably Sarah Le Brocq from Obesity UK, as well as physicians, dieticians, clinical psychologists, nurses and conversation analysts in order to produce this report on how people living with obesity wish to have their condition referred to, so as to improve engagement with health services and ensure we do not contribute to the problem.

It would be amiss not to mention Fenella Lemonsky, a passionate supporter of Language Matters – and who sadly is no more with us – but we are hopeful she would have approved of the work that has been done by all concerned.

As healthcare professionals, we have a gift, a chance to make a difference when we interact with patients. In that limited time of interaction, the least we can do is understand the relevance of what we say – and be appreciative of another person’s life and challenges. Our language matters, and we hope this document will go some way to ensuring the language we choose is appropriate and helpful.

*Drs Charlotte Albury & David Strain
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“Visiting my GP with chest pains, to be told to ‘go home and look in the mirror, as that was what was wrong with me’, to later that evening being rushed into hospital because I couldn’t breathe. I was diagnosed with bronchitis.”

Person living with obesity’

Introduction from Obesity UK

On almost a daily basis, people living with obesity face stigma and discrimination. In the UK and indeed in the NHS, we value inclusion and equality, and thus, people of all backgrounds should have the right to care.

The language we use to describe people with overweight or obesity can have a profound impact on those individuals, leading to stigma and discrimination, which, in many instances, excludes people from leading what would be considered by most to be a 'normal' life.

A common misconception within society is that obesity is simple and is caused by factors solely within someone's control, and thus, obesity is the fault of the individual. Most people have heard, and as children, were taught the phrase, 'don't judge a book by its cover'. However, this important and valuable phrase continues to be overlooked in terms of body shape and size. People with obesity are stereotyped as lazy, uneducated, lacking willpower, binge eaters or eat too much and lack self-discipline, to name just a few. The simplistic viewpoint of obesity as the result of energy intake versus energy expenditure has led to a coining of the phrase 'eat less, move more' which fails to incorporate the evidenced complexity of obesity. Indeed, if obesity was this simple, the substantial and continued efforts, interventions and policies that aim to reduce obesity would mean that the prevalence of overweight and obesity would not be as high.



“ My GP told me I was a drain on the NHS, needlessly taking the contraceptive pill, she said my weight would stop me ovulating. I was pregnant 2 months later and then I was called irresponsible by the consultant for getting pregnant! ”

Person living with obesity

The pervasiveness and ingrained nature of weight stigma and discrimination that is evident across education, workplaces, healthcare and the media, means that people living with obesity internalise these messages, which can lead to physical and mental health problems as well as maladaptive behaviours such as the avoidance of healthcare. Changing the narrative is paramount. The NHS and healthcare can be a trailblazer in supporting this change, which would align with the core values as set out by NHS England.

This language matters guide is much needed. The members of Obesity UK inform us that one of the most common settings where adults and children experience weight stigma and discrimination is in healthcare, a space that should be safe and free from judgement. Healthcare should be inclusive, allowing all people, no matter their reasons for attending, to receive advice, support and where relevant, treatment.

We hope that this guide will also be a stimulant for further work across society that addresses this social justice issue.

“ Had a doctor's appointment to discuss suspected endometriosis, as I was being examined on the table, stripped naked from the waist down... the doctor grabbed a handful of my belly fat, jiggled it about and announced to the nurse, 'she needs to get rid of THIS first'... ”

Person living with obesity

Obesity: Disease or decision?

The medical perspective

“He’s just fat isn’t he; he just needs to be told to get up out of his chair, and stop eating.”

Expert Speaker on type 2 diabetes at a Primary care educational event



It is universally accepted that obesity is a risk factor for multiple conditions: hypertension, dyslipidaemia, cardiovascular disease, type 2 diabetes, arthritis, certain cancers and psychological problems, and is associated with reduced life expectancy and quality of life. However, the underlying causes remain poorly understood. Indeed, in a recent survey of primary care providers, the three most important causes were thought to be physical inactivity, overeating and high-fat diet. They accepted that other factors such as the obesogenic environment play a part, however, there is still a substantial lack of understanding as to the nature of the disease.

The Foresight report of 2007 highlighted over 100 different biological, psychological, environmental and

social potential factors contributing to obesity. These range from genetic pre-disposition or neurochemical imbalances, through the emotional aspects such as boredom or comfort eating, through to simple social pressures that start in childhood with the ‘finish what’s on your plate’.

The mechanisms of this are very complex such that there are fundamental differences in the response to food in people with and without obesity. Although multiple alterations in the brain hormones have been identified, not every person living with obesity has one of these causes. However, irrespective of the underlying cause, once weight gain occurs, the body resists any attempts at weight loss.

Usual physiology responds by lowering the metabolic rate and stimulating increased hunger in order to maintain the new status quo. Thus, even when the person successfully loses weight, weight regain occurs in most and lifelong treatment is required to maintain the new ‘normal’. As such, obesity requires similar ongoing management as many other long-term conditions, and yet is accompanied by a degree of stigma that is unprecedented.

The first step to combatting this, is to get the conversation right, whether that be between healthcare professionals, when engaging with the general public or in clinical encounters between a healthcare professional and a person living with obesity.

Principles and practice



Principles

The following section sets out the principles for good practice for interactions between healthcare professionals and people living with obesity. This was developed with reference to the experience of people with obesity, researchers, healthcare professionals and published research.

- **Seek permission**
 - Unless introduced by the person living with obesity, prior to initiating the conversation, seek the person's permission to discuss their weight
- **Use language (including tone and non-verbal gestures) that is:**
 - Free from judgement or negative connotations, particularly try to avoid the threat of long-term consequences or scolding ('telling off')
 - Person-centred, (also known as 'person-first') to avoid labelling a person as their condition. An example is talking about 'a person with obesity' rather than an 'obese person'
 - Collaborative and engaging, rather than authoritarian or controlling
- **Language has power**
 - Be aware that language, both verbal and non-verbal, has enormous power that can have positive or negative effects
- **Some words are unacceptable**
 - Recognise that some words, phrases and descriptions are potentially problematic, whatever the intention of the user
- **Avoid combat and humour**
 - Avoid using combative language when referring to people's efforts to reduce overweight or obesity, and never use humour or ridicule
- **Stick to the evidence**
 - Communicate, accurate, evidence-based information/ data when discussing weight
- **Don't Blame**
 - Avoid language which attributes responsibility (or blame) to a person for the development of their obesity or its consequences
- **Don't generalise**
 - Avoid language that infers generalisations, stereotypes or prejudice
- **Be empathic**
 - Use or develop an empathic language style which seeks to ascertain a person's point of view of their condition, rather than making assumptions
- **Listen and explore**
 - Listen out for a person's own words or phrases about their weight and body image and explore or acknowledge the meanings behind them
 - Consider how to limit any negative effects from language. Listen out for negative language used by others around you and consider ways to address this





Setting the tone

There are many principles of good communication, including positivity, being helpful and supportive, being collaborative and understanding. Below are some specific applications of these principles to discussions about obesity.

Be positive

- Rather than focusing on the potential harm of obesity, focus on the achieved and potential for improved quality of life, and how these have been, and could be, further realised

Be understanding

- Obesity is commonly misunderstood
- People have often had negative experiences talking to clinicians before
- It is important to understand the wider context that contributes to these discussions

Be aware of non-verbal communication

- Talking about obesity is difficult. Ensure your body language recognises this, by engaging in exactly the same way you would for any other medical condition

Be helpful and supportive

- Offer specific help and advice where appropriate
- Signpost and guide people towards more information and local services
- Be aware of what local services and support you are able to offer
- Talking in general about obesity is less helpful than offering specific advice
- Acknowledge that there are many routes to achieving weight loss: what works for one may not work for all

Be collaborative

- Whenever possible, build specific goals together
- Agree when to meet next to review these goals

Be environmentally aware

- Think about the environment in your clinic as it can add considerable stress ahead of the consultation
- Chairs with arms and weight limits can be restrictive and tight spaces with chairs back-to-back can be hard to navigate between
- Ensure that weighing scales measuring above 150 kg are commonplace and in an area that is private and appropriately sized blood pressure cuffs should be available for all

Starting the conversation

Starting a conversation well can pave the way for a helpful and positive discussion. The following section outlines how healthcare professionals can start conversations about weight management with people with obesity. *Quotes are adapted from real conversations.*

AVOID

Highlighting clinical relevance of weight loss is helpful, but **not when starting the conversation**. This can attribute blame or responsibility to the person for the associated condition:

"I'm sure the problems you've had are all related to your weight."

AVOID

Using **non-clinical terms**, which can be disrespectful, judgemental and inappropriate:

"You're a bit sort of on the chunky side shall we say."

TRY INSTEAD

Asking **permission to discuss weight**, and using an **open-ended question** to find out what the person thinks about their weight. This gives people the opportunity to raise concerns or ask for advice, but also to say that they do not wish to talk about their weight at this time:

"Would you mind if we spoke about your weight? Where do you think you're at?"

TRY INSTEAD

Talk about **'some people'**, rather than **'you' specifically**. This avoids attributing blame but gives space for people to think about how your statement could apply to them:

"Some people with your symptoms, find that losing a bit of weight and a little exercise can be helpful."

AVOID

Starting a conversation in a way which communicates bad news or a 'worst case scenario'. People with obesity are usually aware of their weight or size and this implies the opposite.

“ Ideally your BMI, which is your height in relation to your weight, should be somewhere between 18 and 25... between 30 and 35 you're considered clinically obese... from the measurements that you've had done today, you certainly fall into that category. ”

TRY INSTEAD

Where possible start conversations by referring back to topics people have already mentioned. If someone has already mentioned that they are concerned about an issue, highlight this, and then mention how losing weight could help. This sets up a collaborative conversation:

“ And as you said, your weight's crept up a bit... You said you'd like to lose some weight because you're feeling quite breathless... ”

AVOID

Making assumptions about diet and physical activity. Remember that a person's weight may not reflect their diet and physical activity levels. Do not assume a person is inactive until you have asked about what they currently do:

“ At your weight, you really need to do more exercise. In terms of diet now, you obviously aren't following the diet sheet? ”

TRY INSTEAD

Acknowledge positive actions. Start discussions by acknowledging and congratulating existing positive actions, and use these to make plans for what to do next. Remember, weight loss often comes sometime after changes in lifestyle.

“ It's fantastic that you've taken up swimming. Don't worry that your weight hasn't come down yet, the benefit to your health goes beyond weight loss. ”

Recognise that the term obese can be problematic. Indeed, the word obese is not problematic for a minority of people. Colloquially, the word obese carries negative connotations and can be hugely stigmatising. Although an accepted medical definition, that does not make it an acceptable term to use in a conversation, in the same way one would not describe an individual as 'cancerous' during a consultation.

Talk about being overweight, or possibly carrying too much weight, but only once permission has been sought.



Guiding and signposting

Once you have raised the topic and started the conversation, one of the most helpful things you can do is ask the person if they would be happy for you to offer guidance and signposting to expert services. There are trained experts who can help, but you need to actively offer signposting and referral for this to be beneficial.

You can signpost people to:

- NHS services
- Community services
- Approaches to self-management
- Sources of information and support

When signposting, remind people that they may need to try different things to find out what works for them. Obesity is a chronic relapsing condition and there is no 'quick fix'. Mention that you are there to help. Let people know that if they try something, and it doesn't work for them, they can come back and you can make a new plan together. It is acknowledged that the 'threat' of future complications is not helpful, however, working towards preventing the risk associated with obesity may positively help to avert future problems.



If you're keen to look into managing your weight, there are a few small changes you could make. I could recommend a local service, how would you feel about one of those?



Talking about obesity and overweight with children and young people

In general, the recommendations in this document are relevant for all individuals, however, conversations about growth and weight with young people, and the adults with them, can be particularly sensitive. The section below provides suggestions that can support positive conversations with children and young people.

- Young people, and the adults with them, may be concerned to hear they have obesity or are overweight. Listen to these concerns first, before giving any advice
- If you do provide advice, collaborate with young people and/or the adults with them. Do not make assumptions about their behaviours, and invite their input and thoughts
- Statements like "other young people have said x" or "some young people say y" can help you show the person that they are not alone
- Some statements may imply blame for either the young person, or the adult with them. Think carefully about focusing on small positive changes, rather than negatively commenting on current behaviours



Myth busting in practice – What not to say, and why not

“I’m not going to even talk to this person about weight, because it’s not worth my time.”

Healthcare professionals often avoid talking about weight because they find these conversations difficult, and worry about damaging the relationship between them and the person with obesity.

There is a significant amount of data that demonstrates people *do* want to speak about it; speaking about it and doing something are related.

Evidence shows that after a brief conversation about weight, **14% of people with obesity lost at least 5% of their body weight, another 12% lost at least 10%.**

Provide people with an opportunity to talk about their weight if they would like to. For example, ask a person if they would like to take a few minutes to talk about their weight.

If this is something a person would like to discuss, then it is worth taking some time to have a conversation, and to signpost services and information that can help.

AVOID

“You just need to eat less.”

People living with obesity have lower levels of and/or are insensitive to the hormones that give pleasure from food and cause satiety afterwards. As a result, the main symptom of obesity is hunger, even after eating.

Telling a person living with obesity to “eat less” is like telling a person with asthma to breathe less.

TRY INSTEAD

Focus on the context of people’s lives, for example whether there have been particular circumstances which have led to them eating more or less; this can be a way in which to find out more about their eating experiences and how they might be addressed.

Try asking something like:

“What’s been going on in your life since I last met you? Has this had an impact on what you eat?”



AVOID

Should you be eating that?

People living with obesity often feel criticised or judged by others, including health professionals, about their food choices and eating habits.

Food serves many psychological functions, including emotional regulation and reward.

Healthy eating education is important. However, putting this advice into practice can be a struggle.

For people who are using food for emotional or 'non-hunger' reasons, extra support may be needed.

TRY INSTEAD

Shifting the focus from the 'what' and 'how much' of eating, to exploring the reasons why someone eats the way they do, is more likely to lead to a helpful discussion.

Try an invitation such as:

There are many reasons why we eat, would you like to talk about them?

e.g. eat to manage emotions, eat to fit in or connect with others (socially), eat based on our rules – this often opens up helpful discussion and helps to develop a shared understanding of their eating and weight from which to think about possible solutions.



AVOID

It will all be OK when you lose weight.

Obesity is multifactorial, with many different manifestations. Body habitus is just one of those.

If the person living with obesity successfully loses weight, they still have a lifelong condition that will require maintenance management.

Further, many of the complications of obesity, such as arthritis or coronary artery disease do not resolve. To promise 'cure' is to generate false hope.

TRY INSTEAD

If you were to lose weight, how might life be different?

Focus on the symptomatic improvement that may realistically be achieved.

Determine what the individual would hope to achieve and establish realistic goals to get there.

Remember, a modest 5% weight loss per annum is achievable, maintainable and has been demonstrated to provide long-term benefits.

AVOID

Don't you want to be a normal weight? "

Wrong, on so many levels!

Firstly, weight and body habitus are dependent on culture and environment.

Secondly, achieving a BMI defined 'normal' weight is unlikely to occur within a realistic timeframe, therefore we are setting people up to fail, become despondent and disengage.

Thirdly, when there is no immediate weight loss, this exaggerates the stigma associated with the obesity.

TRY INSTEAD

What would you hope to gain from treatment?

What are your targets; over what timeframe?

How can we achieve these together? "

Very often, individuals will set themselves unrealistic targets. Being realistic from the outset is the best way to maintain engagement and continued collaborative work.

Remember, for many living with obesity, just to maintain current weight without any further gain is a success.

AVOID

If you don't lose weight you *will* get diabetes. "

This is factually wrong! Don't assume that the threat of future ill health will 'motivate' people who 'aren't trying' to lose weight.

Remember, statements like this also imply that someone is to blame for conditions that can be associated with obesity.

TRY INSTEAD

Focus on potential and desired personal gain rather than future risk, e.g.:

You mentioned that you'd like to be able to kick a ball around with your son; if we can lose a very small amount of weight you'll find that type of activity much easier. "

AVOID

Last time we met you said you would do more exercise, but your weight hasn't changed. "

If someone's weight hasn't changed since you last saw them, do not assume that they have not followed your advice. The natural history of a person living with obesity is that weight will progressively climb. Weight neutrality is an achievement for many.

TRY INSTEAD

Instead of prioritising a biomedical outcome, like weight change, as an indicator of 'success', focus on what is important for that person. For example, if someone has previously struggled with exercise, changes to activity levels are a success, irrespective of any change in weight.

Conclusion

Seek to be more

Empathic	(for example, "It sounds as though your weight is really hard to manage at the moment")
Empowering and Inclusive	(for example, "What changes do you feel are needed right now?")
Respectful	(for example, "I appreciate you being open to talk about this")
Trust building	(for example, "I will have a conversation with the team and feed back to you")
Person centred	(for example, "What thoughts have you had yourself about your eating?")
Encouraging and positive	(for example, "I can see the effort you're putting in, keep up the great work!")
Clear	(for example, "Yes, your weight has not come down yet")
Reassuring	(for example, "It is not unusual for people not to lose weight immediately; It's hard work that your body is fighting")
Understanding	(for example, "Now doesn't sound the best time to be concentrating on your weight")
Exploring	(for example, "What makes you say, "I feel like a failure?")
Environmentally aware	(for example, making sure that your clinic and waiting room are appropriate for people who are of a larger size)
Collaborative	(for example, "Let's talk together about the different options and then see what you think would suit you best")
Helpful and supportive	(for example, offer specific help where appropriate, such as a referral, or a dedicated appointment to set goals and make plans)
Congruent words and behaviours	(for example, looking at the person when welcoming or asking questions)
Culturally competent	(for example, exploring individuals' cultural, religious/faith and spiritual beliefs about diabetes)

Seek to be less

Stigmatising	(for example, "You're in denial")
Shaming or blaming	(for example, "It's being so overweight that is causing you to have all these problems")
Authoritarian	(for example, "You must not eat any of these foods")
Demanding	(for example, "Before you come to see me, I want you to complete this food chart, so I can check what's going wrong")
Disapproving	(for example, "You aren't meant to eat that")
Discriminating	(for example, about someone, "I don't think they'd get much from the exercise class")
Stereotyping	(for example, "People from xx background often prefer high fat foods")
Assumptive	(for example, "I think you just need to go for an operation – you won't cope with the other options")
Pre-judging	(for example, about someone, "No-one in that family has ever taken much notice of their weight, they will be the same")
Judgemental	(for example, "That's the wrong choice, it'll never work")
Threatening	(for example, "If you don't loose weight you will end up with your leg chopped off, or just plain dead")



Acknowledgements – The Language Matters Working Group Members

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Claire Jenkins-Bassett	Newcastle Upon Tyne Hospitals
Jennifer Logue	Lancaster University
Abd Tahrani	University of Birmingham
Barbara McGowan	Guy's and St Thomas' Hospital
Jennifer Woodhouse	North Tyneside General Hospital

With thanks to Partha Kar, Consultant Diabetologist

The design of this document was supported by Novo Nordisk

Images used are from The Truth From Within project, which was created and funded by Novo Nordisk in collaboration with photographer Abbie Trayler-Smith

