Incorporating a Health at Every Size approach in Canadian medicine

Recommendations for physician-led patient interventions and how physicians can incorporate Health at Every Size principles into clinical practice and health systems advocacy.

Chloe Gao, BHSc, Amanda Raffoul, PhD

ABSTRACT

There is growing concern among health researchers and clinicians that the widespread use of body mass index (BMI), by which health care decisions are made, may place a misguided focus on weight rather than health. BMI, based primarily on data collected from select populations, has also been criticized for its inability to account for diverse patient populations. Over the past few decades, there has been increased attention to Health at Every Size (HAES), an evidence-informed approach to care that seeks to de-emphasize the focus on weight as a metric for health and promote safe and equitable access to health care for all people. HAES can be used to inform recommendations for physician-led interventions at both the clinical and health care system levels, and we highlight ways that physicians can incorporate HAES principles into clinical practice and health systems advocacy.

Ms Gao is an MD/PhD student in the Faculty of Medicine at the University of British Columbia. Dr Raffoul is an assistant professor in the Department of Nutritional Sciences, Temerty Faculty of Medicine, at the University of Toronto.

Corresponding author: Ms Chloe Gao, gaoc1234@student.ubc.ca.

This article has been peer reviewed.

In June 2023, the American Medical Association (AMA) released a policy statement that acknowledged concerns with the widespread use of body mass index (BMI) "due to its historical harm, its use for racist exclusion, and because BMI is based primarily on data collected from previous generations of non-Hispanic white populations."[1] The Canadian Medical Association has, for the most part, remained silent on this issue. We argue that the widespread use of BMI in Canada may lead to missed diagnoses and poorer quality of health care among diverse patient populations. We also posit an alternative paradigm that could be implemented in health care settings to promote health and well-being.

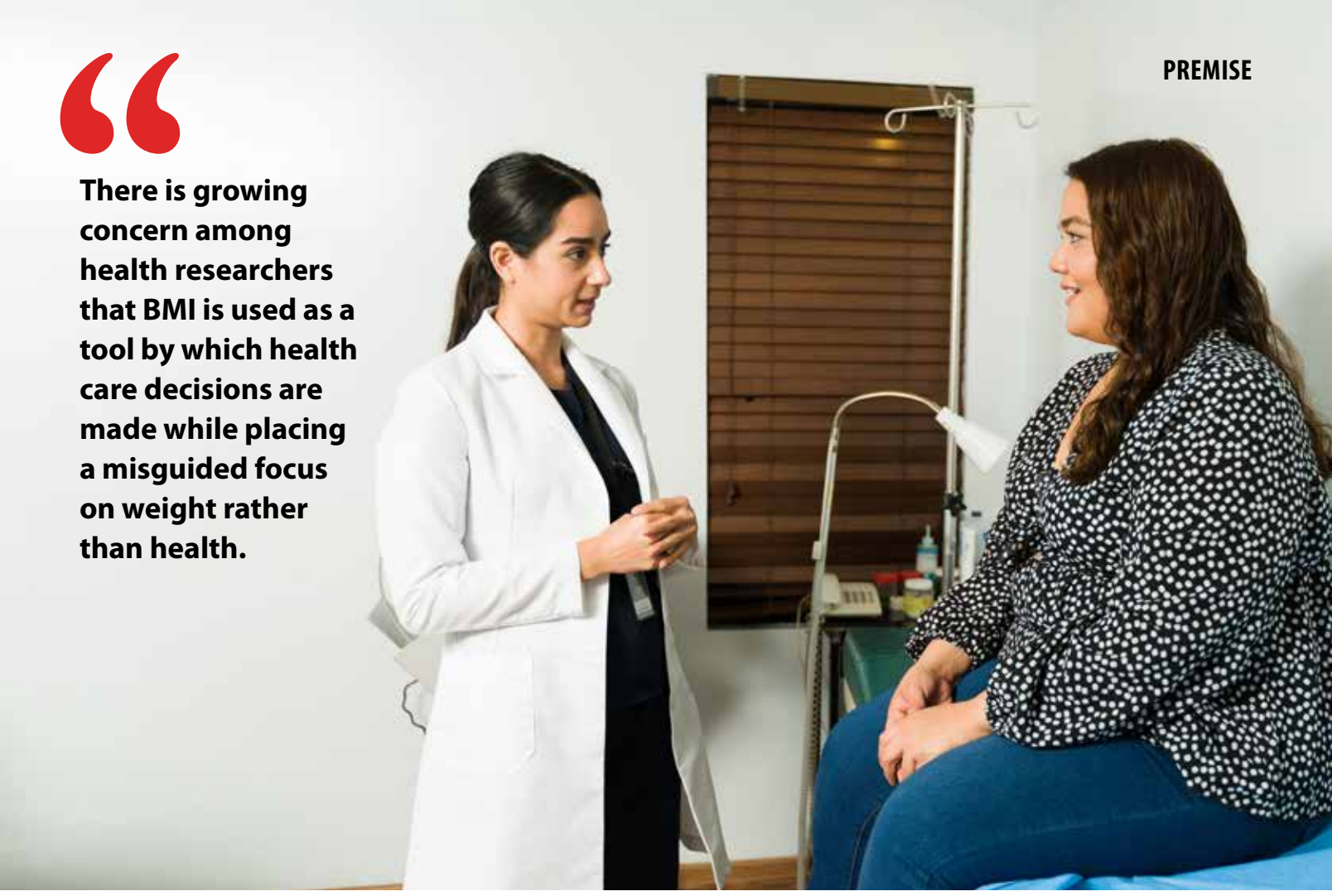
The problem with BMI

In the mid-1830s, Belgian mathematician Lambert Adolphe Jacques Quetelet developed the construct of BMI by collecting data on the heights and weights of White European cisgender men at varied ages.[2,3] His initial goal was to determine the proportions of the "average" man—a concept that is now recognized as a foundational element of eugenics.[4] Accordingly, the use of BMI in clinical settings can have limitations, given its inability to account for the diversity among our patient populations.[2,3]

Since the establishment of BMI as a common measure of health, it has been indiscriminately applied to populations, including different ethnic groups, in such a way that may have contributed to worse health outcomes for people of color.[4] Authors of one population-based cohort study in England found that individuals from South Asian, Black, Chinese, and Arab populations developed type 2 diabetes at significantly lower BMI cutoffs than White populations.[5] Not only does this highlight the limitations of BMI as a universal indicator of health outcomes, it also emphasizes the harm that its application can cause by leading to delayed screening and diagnosis of type 2 diabetes for ethnic minority adults.[5] As a result of this, race-specific BMI cutoffs have been created for type 2 diabetes by the World Health Organization and the National Institute for Health and Care Excellence.[5] However, considering racialized communities already experience intersecting barriers to accessing health care services, including linguistic, socioeconomic, and cultural barriers,[6] applying a Eurocentric measure of health to such communities further exacerbates existing health care disparities.[6-9]

There is growing concern among health researchers that BMI is used as a tool by which health care decisions are made while placing a misguided focus on weight rather than health.[10] Reliance on BMI can cause physicians to miss critical diagnoses, such as the very common occurrence of eating disorders occurring in people with normal or higher BMIs.[11] The widespread use of BMI also perpetuates weight bias in health

There is growing concern among health researchers that BMI is used as a tool by which health care decisions are made while placing a misguided focus on weight rather than health.



care settings through its focus on weight as the sole indicator of health, which can negatively impact patient–physician trust and hinder people from seeking medical care due to fear that they will be told to lose weight and have their health concerns dismissed.[11]

What can be done?

In the AMA's 2023 policy statement on the limitations of BMI, it was suggested that BMI should be used in conjunction with other measures of health risk, such as "measurements of visceral fat, body adiposity index, body composition, relative fat mass, waist circumference, and genetic/metabolic factors."[1] However, we propose that health can and should look beyond fat- and weight-focused measurements—an idea endorsed by the Health at Every Size (HAES) approach.[12] The implementation of a HAES approach may provide a means of addressing weight, nutrition, and body image in a more person-centred and equity-oriented fashion.[3]

What is HAES?

HAES is an evidence-informed approach to care that seeks to de-emphasize the focus on weight as a metric for health and promote safe and equitable access to health care for all people, irrespective of their weight.[12] It has roots in 1960s civil rights movements and developed into its current form in the 1990s.[12] HAES does not condone weight loss, but rather discourages disordered eating and weight control behaviors while recognizing the plurality of what it means to be healthy.[3]

In 2003, the Association for Size Diversity and Health, a not-for-profit organization committed to size diversity in health, created the first version of the HAES principles, most recently revised in 2024.[12]

Current HAES principles are:

- Health care as a right for everyone, irrespective of body size.
- Health, well-being, and healing are strengths that are both community-centred and personal, with people being the experts of their own needs, health, well-being, and healing.
- Person-centred care should be offered to people of all sizes and should actively address anti-fat bias.
- Health is a sociopolitical construct that reflects evolving societal norms and values and necessitates continuous and critical examination.[12]

To date, studies have found that the benefits of HAES interventions on eating behavior and mental health and well-being outweigh the potential risks of weight loss interventions.[3,13]

HAES in action

HAES can be used to inform recommendations for physician-led interventions at both the clinical and health care system levels.[3] At the clinical level, there are many ways that physicians can implement HAES principles into their clinical practice. First, HAES warrants that physicians acknowledge their own weight bias and how it may impact their clinical care, especially when interacting with higher-weight patients.[3] During appointments, it may be helpful to avoid focusing discussions on weight loss and use patient-identified, nonstigmatizing language when speaking with patients about their bodies (e.g., larger- or smaller-bodied instead of obese or skinny).[3,14] Physicians should avoid labeling certain weights or bodies as healthy or unhealthy and bad or good, to disentangle weight from health and morality.[10] Additionally, ensure the images in your clinic do not perpetuate stigma against people living in larger bodies in patient education materials, clinic decor, and reading materials (e.g., using images of larger bodies with their heads cropped off—the "headless fatty" portrayal) to create a safe space for people living in larger bodies through respectful representation.[15-17]

Instead of traditional weight-centric approaches to health, the HAES approach encourages engagement in multifaceted behavioral interventions.[3,18] Furthermore, when engaging in these conversations, it is important to explore patients' feelings in a compassionate and open-minded manner about any lifestyle counseling suggestions (e.g., dietary habits, physical activity behaviors, sleep hygiene) to uncover the basis of their behaviors and how to support behavioral change.[18] Recommendations should focus on adding healthy behaviors and activities to patients' current lifestyle, rather than emphasizing restrictions.[3] These can include finding exercises and activities that bring patients joy and contribute positively to their overall mental and physical well-being (e.g., active embodiment), or working toward adopting intuitive eating, the mindful consumption of food in response to internal bodily regulation processes such as hunger and satiety cues, in lieu of cognitive dietary restriction.[3,12] Moreover, physicians working in weight-focused settings should ensure that people presenting to these clinics receive comprehensive assessment and care in such a way that weight stigma and weight-centric approaches to health do not result in lower-quality care or missed diagnoses of critical illness (e.g., eating disorders occurring at higher weights).[11]

Instead of traditional weight-centric approaches to health, the HAES approach encourages engagement in multifaceted behavioral interventions.

Physicians can advocate for the broader incorporation of HAES principles into Canadian medical establishments through academic teaching and mentorship of trainees and their clinical practices.[19] For example, during bedside teaching of medical students, residents, and fellows, clinical instructors can discuss HAES principles and how they can be applied during patient interactions. Physicians teaching didactic lectures in primary care and public health topics such as nutrition and physical activity can incorporate HAES principles such as active embodiment and intuitive eating into their lectures.[12] As HAES has not yet been widely implemented, it is also important to share what you learn and know about this holistic approach to health with your health care colleagues.

In short, Canadian physicians should not only heed the AMA's position paper about the shortcomings of BMI in clinical contexts, but also go beyond the focus on weight- and size-centric measurements and support high-quality, patient-centred care for people of all sizes by implementing HAES principles into their clinical practices, education and training, and advocacy efforts [Box]. ■

BOX. Key recommendations for physicians.

- Acknowledge weight bias and how it may impact clinical care.
- Use patient-identified, nonstigmatizing language when speaking with patients about their bodies.
- Avoid labeling certain weights or bodies as healthy or unhealthy and bad or good.
- Ensure images in your clinic do not perpetuate stigma against people living in larger bodies.
- Encourage engagement in multifaceted behavioral interventions that are not weight focused.
- Focus on adding healthy behaviors and activities (e.g., active embodiment and intuitive eating) rather than introducing restrictions.
- Ensure patients presenting to weight-focused clinics receive comprehensive assessment and care that are not defined by their weight or BMI (e.g., do not offer specific services or ask specific questions only because of a patient's weight).
- Advocate for the broader incorporation of Health at Every Size principles into Canadian medical establishments through teaching and mentorship of trainees.

Competing interests

None declared.

References

1. American Medical Association. AMA adopts new policy clarifying role of BMI as a measure in medicine. 14 June 2023. Accessed 18 September 2024. www.ama-assn.org/press-center/press-releases/ama-adopts-new-policy-clarifying-role-bmi-measure-medicine.

2. Jacobs AE. How body mass index compromises care of patients with disabilities. AMA J Ethics 2023;25:E545-E549.
3. Raffoul A, Williams L. Integrating Health at Every Size principles into adolescent care. Curr Opin Pediatr 2021;33:361-367.
4. Strings S. How the use of BMI fetishizes White embodiment and racializes fat phobia. AMA J Ethics 2023;25:E535-E539.
5. Caleyachetty R, Barber TM, Mohammed NI, et al. Ethnicity-specific BMI cutoffs for obesity based on type 2 diabetes risk in England: A population-based cohort study. Lancet Diabetes Endocrinol 2021;9:419-426.
6. Shepherd SM, Willis-Esqueda C, Paradies Y, et al. Racial and cultural minority experiences and perceptions of health care provision in a Mid-western region. Int J Equity Health 2018;17:33.
7. Strings S. Fearing the Black body: The racial origins of fat phobia. New York, NY: New York University Press; 2019.
8. Hardy KA. Five ways health care can be better for fat people. AMA J Ethics 2023;25:E528-E534.
9. Gillispie-Bell V. The contrast of color: Why the Black community continues to suffer health disparities. Obstet Gynecol 2021;137:220-224.
10. Tylka TL, Annunziato RA, Burgard D, et al. The weight-inclusive versus weight-normative approach to health: Evaluating the evidence for prioritizing well-being over weight loss. J Obes 2014;2014:983495.
11. Ramaswamy N, Ramaswamy N. Overreliance on BMI and delayed care for patients with higher BMI and disordered eating. AMA J Ethics 2023;25:E540-E544.
12. Association for Size Diversity and Health. Health at Every Size principles. Accessed 18 September 2024. https://asdah.org/haes/.
13. Penney TL, Kirk SF. The Health at Every Size paradigm and obesity: Missing empirical evidence may help push the reframing obesity debate forward. Am J Public Health 2015;105:e38-e42.
14. Sonneville KR, Mulpuri L, Khreizat I, et al. Youth preferences for weight-related conversations. Health Commun 2020;35:1328-1333.
15. Puhl RM, Peterson JL, DePierre JA, Luedicke J. Headless, hungry, and unhealthy: A video content analysis of obese persons portrayed in online news. J Health Commun 2013;18:686-702.
16. McClure KJ, Puhl RM, Heuer CA. Obesity in the news: Do photographic images of obese persons influence antifat attitudes? J Health Commun 2011;16:359-371.
17. University of Connecticut Rudd Centre for Policy and Health. Guidelines for media portrayals of individuals affected by obesity. 2014. Accessed 18 September 2024. https://uconnruddcenter-org.media.uconn.edu/wp-content/uploads/sites/2909/2020/07/MediaGuidelines_PortrayalObese.pdf.
18. Miller WC. The weight-loss-at-any-cost environment: How to thrive with a health-centered focus. J Nutr Educ Behav 2005;37(Suppl 2):S89-S93.
19. Tse A, Xavier S, Trollope-Kumar K, et al. Challenges in eating disorder diagnosis and management among family physicians and trainees: A qualitative study. J Eat Disord 2022;10:45.