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Bad words: why language counts in our work with bariatric patients

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Abstract Language is powerful. Our words convey our impressions, attitudes, and worldview. Language not only reflects, but also shapes, the way that we think. In the field of bariatric-metabolic surgery, it is critical for clinicians to choose our language thoughtfully. In this paper, we demonstrate the importance of language choices in our clinical work and our professional communications; explore the potential pitfalls of words and phrases commonly used in the field of obesity; and encourage the use of more productive language choices in our communications with patients and professional colleagues, both within and outside of our field. (Surg Obes Relat Dis 2018;■:00–00.) © 2018 American Society for Metabolic and Bariatric Surgery. All rights reserved.

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If a group of obesity treatment providers was asked to list the tools that are available to help patients manage their weight, resources such as medications, surgical instruments and devices, activity monitors, exercise equipment, dietary counseling, or behavioral treatment might first come to mind. What may be less obvious to these providers is the one tool they all have at their disposal, a simple but powerful tool that is often overlooked: human language.

Merriam-Webster defines "language" as the words or signs people use to express their thoughts [1]. Our words convey our impressions, our feelings, and the attitudes we hold. They also provide insight into how we see the world—including our judgment of our patients and the way we make sense of their struggles. However, the words we use do not just reflect our worldview; they powerfully shape it as well. We think in words, and thus the words we choose shape the way we think. For instance, in languages that assign a gender to the words for neutral objects like a bridge or a key, the adjectives that speakers choose to describe these objects will vary depending on the gender of that object. In German, the word for "key" is masculine, while in Spanish, it is feminine. Consequently, when asked to describe a key, German speakers tend to choose descriptors like "jagged" and "hard," while Spanish speakers choose descriptors like "tiny" and "delicate," despite the fact that they are describing the very same object [2].

Language choices have been found to influence what details we attend to during communication and the type of information we remember. Language choices also shape the attributions we assign to the phenomena we observe, and they play a role in the approaches we choose to solve problems [3,4]. These findings have important implications in domains, such as policy and healthcare. For instance, when crime is metaphorically described as a "beast,"

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individuals are more likely to support the implementation of aggressive tactics, such as increasing the size of the police force. However, when crime is described as a "virus," respondents are more likely to favor tactics such as increasing social programs [5]. This finding suggests that language choice has an impact on the narrative to which one subscribes when explaining a phenomenon. Perhaps unsurprisingly, the narrative around the etiology of obesity has been shown to impact attitudes toward policy. In a recent study, people who agreed with a narrative that blamed individuals for their weight were more likely to support the use of penalties, while those who understood obesity in terms of environmental contributors were more inclined to support polices designed to protect people with obesity [4].

It is especially important to acknowledge that many of the topics relevant to the fields of obesity and bariatric-metabolic surgery often carry considerable "emotional baggage" due to the social stigma associated with obesity, which makes it particularly critical for clinicians in this field to choose our language thoughtfully. In short, of all the tools we have at our disposal for patients who have obesity, language is among the most crucial.

The aims of this paper were to demonstrate the importance of language choices in our clinical work and our professional communications; to increase awareness of the potential pitfalls of words and phrases commonly used in the field of obesity; and to encourage the use of more productive language choices in our communications with patients and professional colleagues, both within and outside of the obesity field.

The power of language in our work with our patients

The outcomes of our interventions with patients will depend a great deal upon our language in a number of different ways. One important determinant of treatment outcomes is the strength of the working alliance between the clinician and the patient [6,7]. Consultation and advice from even the most brilliant surgeon, nurse, physician, dietician, or behavioral health provider is unlikely to be effective—or even heard—if the patient does not trust that the provider understands his or her experience. The language we use can subtly but powerfully convey empathy and respect for our patients, or lack thereof.

Language and stigma

Perhaps one of the most powerful ways that language can affect our relationship with our patients is the extent to which our words suggest, accurately or not, that we hold stigmatizing beliefs and negative biases that characterize people with obesity as lazy and lacking self-discipline, among other negative and blaming stereotypes. It is well established that weight-related stigma is pervasive in our culture [8–10]. Regrettably, this stigma is present among healthcare providers [11,12], even those who specialize in working with patients who have obesity [13,14]. Stigmatizing communications between healthcare providers and their patients may be damaging in at least 2 different ways. First, expecting and experiencing weight stigma from healthcare providers can lead patients to avoid seeking medical attention and is associated underutilization of recommended medical screening and preventive care [12,15,16]. Second, being subjected to weight-related stigma from a respected provider may contribute to patients internalizing these stigmatizing beliefs about themselves. Importantly, internalized weight stigma has been found to be associated with binge eating, poorer health-related quality of life, lower levels of physical activity, and even elevated cardiometabolic risk [17–21]. Furthermore, internalized weight stigma may prevent patients from seeking much-needed medical treatment; if they feel their weight is due to some personal failing or is entirely their "fault," they may not feel deserving of help for their weight-related problems. In fact, if patients feel that their weight is entirely their "fault," they may be less willing to consider weight loss surgery as a treatment option, believing instead that they simply need to "try harder" or perhaps do not "deserve" to have surgery.

Language and stigma are tightly intertwined when considering the quality of our relationship with our patients, as the words we choose can serve either to perpetuate or to combat weight-related stigma and uninformed attitudes about obesity and obesity treatments. A number of words and phrases commonly used in our field may promote weight stigma and thus interfere with the quality of our relationship with our patients and the care they receive. We will review examples of such terms, discuss reasons why they are counterproductive, and suggest alternative language choices (see Tables 1 and 2).

Obese

Of all of the counterproductive terms to be considered, "obese," when used as an adjective, is perhaps the one used most pervasively, both within our field and outside of it. Although it may seem like a subtle nuance, using the word "obese" to describe a patient serves to effectively equate the patient with his or her obesity. An increasingly prevalent principle in many areas of medicine today is the concept of using "person-first" language [22], which entails referring to a medical condition as a noun, rather than an adjective. For example, rather than saying "obese patients are at risk for hypertension," we would instead state that "patients with obesity are at risk for hypertension." Person-first language distinguishes the patient from the condition; in the words of Kyle and Puhl [22], "Obese is an identity. Obesity is a disease." Importantly, the American Society for Metabolic and Bariatric Surgery and all members of the Obesity Care Continuum have recommended that person-first language be the standard in all publications and presentations [22];

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