VIEWPOINT

Respectful Language and Care in Childhood Obesity

Fatima Cody Stanford, MD, MPH, MPA
Department of Pediatrics, Endocrine Division, Massachusetts General Hospital, Boston; and Harvard Medical School, Boston, Massachusetts.

Theodore K. Kyle, RPh, MBA
ConscienHealth, Pittsburgh, Pennsylvania.

For many years, obesity has been the most prevalent chronic disease in the United States. In pediatrics, obesity is classified as follows: body mass index (BMI) of 95% or greater of the 95th percentile as class I (mild), BMI of 120% or greater of the 95th percentile as class II (moderate), and BMI of 140% or greater of the 95th percentile as class III (severe). Current estimates suggest that 16.8% of youths between the ages of 2 and 20 years and 39.6% of adults have obesity.[1] The rate of severe obesity is increasing most rapidly, with severe obesity now affecting approximately 5 million youths. Nevertheless, the medical community has been slow to discard pervasive thinking of obesity more as a lifestyle choice than as a complex multifactorial disease.

Obesity results from the interaction of genetics, environment, development, and behavior. The American Medical Association resolved that obesity should be regarded as a disease in 2013,[2] but the adoption of this view is not yet universal.[2] Even among physicians, understanding of the biological basis for obesity is incomplete.[3] The combination of high prevalence and inadequate care for the children affected means that obesity represents one of the most serious threats to a lifetime of health for children today. Modeling of growth rates suggest that 57% of current children are likely to have obesity by the time they reach the age of 35 years.[4]

The Harm of Weight Stigma

Stigma causes harm that rivals or exceeds the physical harm of obesity. That harm is especially great in children and adolescents. It begins as early as the age of 3 years. Some physicians and parents mistakenly believe that stigma and shame will motivate individuals to lose weight, but instead it leads to long-lasting negative health consequences. Research has documented that avoidance of medical care, binge eating, less physical activity, and increased weight gain are more likely when patients experience bias and stigma.[5] Youths are especially vulnerable.[5]

The physical harm of obesity accumulates slowly over time and may not be seen clinically for years, but the harm that stigma causes is immediate and profound. Bullying, depression, anxiety, substance abuse, low self-esteem, and poor body image are important risks that increase when a child or adolescent experiences weight stigma.

The Importance of Respectful Language

Unfortunately, patients report that health care workers often never see past a patient's obesity. They find that symptoms they present to health care workers are often attributed to obesity even when they are medically unrelated. When a physician labels a patient as obese, it establishes such thinking at the outset. In few other diseases may it be so commonplace for patients to be labeled with a disease than it is with obesity. The best practice is to be clear that the patient has a disease but that they are not defined by it.

We rarely see patients referred to as diabetic, and it is even less common to apply such labels to patients who have cancer. However, in everyday interactions with patients and in the medical literature, we often see the terms *fat*, *obese*, and *morbidly obese* even though these terms are the most stigmatizing and least motivating. This response to such language has been documented both for adults and in a study of parents with children between the ages of 2 and 18 years.[5,6]

Language can set the tone for productive dialogue with youths and parents or it can prevent dialogue from ever happening. Research suggests that a physician labeling a child with stigmatizing language can lead to parents seeking a different physician or avoiding medical appointments for their children altogether. Labeling children with stigmatizing language leaves parents feeling blamed for their child's condition. Not only is blame counterproductive, it obscures the complexity of the many factors that cause obesity.

Guidance for Respectful Language

In a recent joint policy statement, the American Academy of Pediatrics (AAP) and The Obesity Society called for action to reduce the significant harm associated with bias and stigma that children and adolescents with obesity endure.[5] Their statement documented the harm that stigma can cause and proposed 10 actions to reduce that harm. A key element of these recommendations focuses on the use of respectful language, including people-first language such as *a patient with obesity* as opposed to *obese patient*. Such language offers a respectful framework for separating discussions of the condition from the identity of the patient. *Fat*, *obese*, and *morbidly obese* are examples of terminology that is unhelpful.

The goal, as recommended by AAP, is for physicians to model unbiased language and behavior as a step toward reducing the harm of weight stigma and bias. The AAP encourages using neutral terms, such as *weight* and *body mass index*, for a more positive response from patients and parents coping with obesity. Terms such as *obese*, *morbid obesity*, and *excessively fat* set up a demeaning conversation. Using people-first language means that the patient comes first and obesity surfaces as only a medical condition. Physicians should take cues from patients and parents about acceptable terminology. Motivational interviewing skills can help in finding constructive language. In addition, the clinic environment, including staff and physical facilities, can play a role in either stigmatizing or welcoming patients and families with obesity.[5] But in no case does labeling a patient as an obese child enhance a child's self-concept.

Consistent with AAP guidance, the American Medical Association (AMA) House of Delegates passed a resolution (H-440.821) at its 2017 annual meeting to "discourage the use of stigmatizing terms including obese, morbidly obese, and fat," and to encourage the use of people-first

Corresponding Author: Fatima Cody Stanford, MD, MPH, MPA, Department of Pediatrics, Endocrine Division, Massachusetts General Hospital, 50 Staniford St, Ste 430, Boston, MA 02114 (fstanford@mgh.harvard.edu).

language throughout obesity-related literature.[7] Though obesity journals are more uniformly adhering to AMA style regarding people-first language,[8] the lack of people-first language in obesity-related literature can still be found in many major medical journals.

Advancing the Quality of Care for Obesity

Respectful language is a first step toward respectful care for patients with obesity.[9] Language alone cannot guarantee that interactions with patients and families will be effective and centered on the needs of patients and families. However, without a foundation of respect signaled by respectful language, patient- and family-centered care will not be possible for families facing the challenges that obesity presents.

Systemic issues remain to be solved so that pediatricians can more consistently deliver evidence-based care for childhood obesity. Respectful language is an important step toward resolving one of those issues: pervasive bias and stigma. We encourage *JAMA Pediatrics* to require that the articles that it publishes adhere to the guidance of AMA style and consistently use people-first language in publications regarding obesity.

ARTICLE INFORMATION

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VIEWPOINT

The Affordable Care Act, Breastfeeding, and Breast Pump Health Insurance Coverage

Kandice A. Kapinos, PhD
RAND Corporation, Arlington, Virginia.

Lindsey Bullinger, PhD
Georgia Institute of Technology, School of Public Policy, Atlanta.

Tami Gurley-Calvez, PhD
Department of Health Policy and Management, University of Kansas Medical Center, Kansas City.

Corresponding Author: Kandice A. Kapinos, PhD, RAND Corporation, 1200 S Hayes, Arlington, VA 22202 (kkapinos@rand.org).

The Patient Protection and Affordable Care Act (ACA) required private health insurers to cover breast pumps for new mothers without cost sharing through the preventive service mandate (§2713) starting in late 2012. With 49% of all births in the United States covered by private health insurance, this mandate has the potential to affect approximately 1.9 million women and their infants each year.[1] Evidence suggests that this policy change resulted in more mothers attempting breastfeeding,[2] as well as breastfeeding for a longer period.[3]

One large health insurer (Anthem Blue Cross Blue Shield), with an estimated 74 million enrollees, has recently rolled back the value of the breast pump benefit, reducing reimbursement for the medical equipment from $169 to $95. Although some analysts have suggested that this is simply the insurer renegotiating with medical supply providers, it is unclear whether this change will affect the availability of high-quality breast pumps that are available to covered mothers. However, standard economic theory suggests that medical equipment suppliers would provide lower-cost units as the price that they are reimbursed declines.

Whether changing the quality of breast pumps available will result in fewer mothers using these benefits or affect breastfeeding initiation or duration is unclear. Evidence has shown that electric pumps extract more milk than manual pumps on average,[4] and there is considerable heterogeneity across electric pumps in milk output. Therefore, if lower-quality pumps result in less milk expression, this will have implications for the mother's milk supply, which may affect the length of time that she is able to breastfeed. A lower-quality pump may also increase the time required to pump, which will likely deter women from continuing to use the pump.

Breast pumps are critical for mothers who need to be separated from their infants for work or school and can also stimulate milk production when mothers face milk supply challenges.[5] The "business" case for breastfeeding has been made that employers may face reduced employee health care costs and attract and retain productive employees. Similarly, national estimates of health care cost savings suggest that, if 80% of mothers breastfed for 6 months exclusively (ie, without formula supplementation), the United States could save $10.5 billion (in 2007 US dollars) in reduced health care costs during the infant's first year of life.[6] The cost savings for infants who were breastfed for 6 months, but not exclusively, may be lower. However, these cost savings may also be a vast underestimate because they