REVIEW ARTICLE

Patient-centered care and "people-first language" as tools to prevent stigmatization of patients with obesity

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ABSTRACT

Obesity is a global health problem with serious consequences, such as diabetes, dyslipidemia, cardiovascular disease, infertility, and certain cancers. Excess body weight, mainly due to its manifestation in an individual's appearance, also affects the psychological condition. Therefore, health care providers need to make an effort to diagnose and comprehensively treat obesity. The obesity treatment should be systemic and carried out by a multidisciplinary therapeutic team consisting of a doctor, nurse, dietitian, psychologist or physiotherapist, and surgeon. The first-line therapy of obesity includes lifestyle modification and increased physical activity. Pharmacological treatment is recommended in all adult patients with a body mass index (BMI) exceeding 30 kg/m^2 or those with a BMI greater than or equal to 27 kg/m^2 with at least 1 obesity-related comorbidity. Bariatric surgery should be considered in adults with a BMI of 40 kg/m^2 or greater, or those with a BMI greater than or equal to 35 kg/m^2 with at least 1 obesity-related disease. The holistic model of obesity treatment also includes psychological therapy. The European Association for the Study of Obesity recommends psychological assistance for all individuals with previous treatment failure. Adverse or harmful actions toward people with obesity, ascribing negative traits and behaviors to them, and their marginalization in the public space are referred to as stigmatization of obesity. This phenomenon is associated with reduced compassion and willingness to help, and a feeling of dislike or even anger toward this group of patients. The consequences of stigmatization are worse mental health, poorer physical health, avoidance of health care, and the maintenance or increase of excess body weight. Therefore, talking about obesity using the principles of "people-first language," as well as implementing a patient-centered care model are important.

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Obesity: definition and epidemiology Obesity is defined as excessive fat accumulation (adiposity) caused by an energy imbalance related to neurohormonal disorders in regulating food intake and energy expenditure. It is a chronic disease with no tendency to self-remit, characterized by progression and frequent relapses.[1] This prevalent and complex disease, with the *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision* (ICD-10) code E.66*, increases the risk of long-term medical and sociopsychological complications, reduces lifespan, and increases health care costs. In developed countries, the financial expenses related to obesity are estimated at 2% to 7% of the total health care costs. However, these data are likely underestimated due to the fact that mostly complications of obesity are reported, and not their primary cause, that is, obesity itself.

Obesity is a global health problem with a growing prevalence. According to a World Health

Organization (WHO) report, more than 1.9 billion people worldwide are overweight, and this number is still increasing.[1] In Poland, it is estimated that 53% of women and 68% of men are overweight, and 1 in 4 adults is obese. The prevalence of overweight and obesity has risen dramatically also among children and adolescents. A Polish National Health Fund report showed that in this population, the prevalence of obesity increased from 8% in 2007 to 13% in 2016 in boys, and from 3% in 2007 to 5% in 2016 in girls, while the prevalence of overweight in 2016 was approximately 26%.[2]

Clinical characteristics and consequences of obesity

The pathogenesis of obesity is multifactorial and may have a genetic, medical, and environmental background. Genetic causes of excessive fat accumulation include single-gene mutations, primarily located in the leptin-melanocortin pathway (eg, leptin, leptin receptor, and proopiomelanocortin [*POMC*] mutations, deficiencies in melanocortin receptor or proprotein convertase-1/2), the syndromic forms of obesity (Bardet–Biedl syndrome, Prader–Willi syndrome, Alström and Cohen syndromes), and epigenetic factors.[3,4] Among the medical conditions leading to obesity are endocrine abnormalities, central nervous system disorders (organic damage to the hypothalamus), and effects induced by drugs (steroid hormones, antipsychotics, antidepressants, antiepileptic drugs).[5]

Environmental factors, such as a Western-style diet, hypercaloric diet, physical inactivity, and sedentary lifestyle, are widely recognized as the reasons for excessive weight gain.[6] The fact that these factors are modifiable contributes to the widespread discrimination and stigmatization of patients with obesity. It must be mentioned that obesity, as a psychosomatic disease, is also conditioned by psychological factors, including depression, serious mental illnesses (eg, schizophrenia, bipolar affective disorder), and eating disorders.[7]

The diagnosis of obesity is relatively simple and includes anthropometric measurements (body mass, weight, body mass index [BMI], waist circumference [WC], hip circumference, waist-to-hip ratio) and, optionally, other methods of body mass composition analysis (skinfold thickness, bioelectrical impedance, densitometry [underwater weighing, air plethysmography, dual-energy X-ray absorptiometry]). However, previous studies indicate that obesity is often undiagnosed and undertreated, and the median time to establish the diagnosis is 5 years. What is more, only 55% of people with adiposity are diagnosed with obesity.[8]

The operational definition of obesity is based on BMI. The WHO and international guidelines recommend BMI cutoffs of 25 kg/m^2 and 30 kg/m^2 to diagnose overweight and obesity, respectively.[1] However, BMI is not an accurate tool for identifying the risk for development of obesity-related complications. WC, measured at the mid-point between the lower costal margin and the iliac crest, is the most practical clinical measure for assessing the severity of abdominal obesity and the risk of metabolic syndrome (MetS) and cardiovascular disease (CVD). According to the International Diabetes Federation, WC greater than 80 cm in women and greater than 94 cm in men indicate abdominal obesity, while WC greater than 88 cm in women and greater than 102 cm in men are associated with a substantially increased risk for CVD and MetS. Measurements of the height, weight, WC, and BMI should be an integral part of the physical examination.[9]

The diagnosis of obesity should be accompanied by an in-depth assessment of complications resulting from excess body weight, for example, coronary artery disease, type 2 diabetes mellitus (T2DM), dyslipidemia, obstructive sleep apnea and other sleep disorders, gallstones, musculoskeletal disorders, varicose veins and edema of the legs, and others. Additionally, women of childbearing age should be asked about the regularity and length of their menstrual cycles, and men, about possible problems with erection. Laboratory workup should include complete blood count, thyroid-stimulating hormone, cortisol, liver transaminases, uric acid, creatinine, sodium and potassium level assessment, as well as a urine examination.[10]

According to the European Association for the Study of Obesity (EASO) recommendations,[11] patients with obesity should also undergo a clinical psychological evaluation, assessing the risk for or confirming the presence of eating disorders (binge eating disorder, night eating syndrome, psychological bulimia), depression, and other mood disorders, as well as psychosocial factors leading to weight gain, chronic stress, and motivation to change.

Obesity can lead to many diseases and health problems, such as T2DM, dyslipidemia, CVD (high blood pressure, heart disease, stroke), musculoskeletal disorders, infertility, and certain cancers (eg, endometrial, breast, ovarian, prostate, liver, gallbladder, kidney, colon).[12] It also increases susceptibility to an unfavorable course of acute infections, such as COVID-19. It has been shown that in COVID-19–positive individuals, the risk of thromboembolic and ischemic complications (eg, stroke, disseminated intravascular coagulation), severe hyperglycemia, and leukoencephalopathy is greater in the population with obesity than in patients with normal body weight. Additionally, patients with excessive fat mass experience more severe COVID-19 complications, such as cardiomyopathy, dysrhythmias, endothelial dysfunction, acute kidney injury, dyslipidemia, lung lesions, and acute respiratory distress syndrome. At the same time, the COVID-19 pandemic and restrictions associated with lockdown may have significantly increased the number of people with obesity.[13,14]

Excess body weight, mainly due to its manifestation in an individual's appearance, harms

their psychological functioning / condition. Obesity may lead to negative experiences related to the body image, self-esteem, emotional functioning, and social relations.[15] People with obesity experience appearance-related shame and tend to feel guilty, helpless, sad, and angry. They may be submissive, withdrawn, and distrustful in relations with other people. They also often experience social distancing and loneliness, which in turn affects their health and mental well-being. It has been observed that patients with obesity face prejudice, discrimination, and stigmatization due to their weight, which contribute (independently of the BMI) to their increased morbidity and mortality.[16,17] Some people with obesity develop various types of mental disorders. It is estimated that such disorders may affect 30% to 40% of men and 50% to 60% of women with the disease. The most prevalent ones are depression (23%–84%) and anxiety disorders (7%–54%).[18] Dissatisfaction with one's appearance, depression, and anxiety are more prevalent in the individuals with obesity seeking treatment than in those coping on their own.[7]

Obesity can also lead to a significant economic burden on the health care system.[19]

Because of the wide range of negative consequences of the disease, health care providers need to focus on early diagnosis and comprehensive treatment of obesity.[20]

Therapy of obesity **Behavioral interventions** According to the European practical guidelines,[21] a reduction of body weight by 5% to 15% over 6 months has proven health benefits in patients with obesity. However, it should be emphasized that the weight loss objectives must be individualized, realistic, and long-term. What is more, the aim of obesity treatment is not only to reduce and maintain the body weight, but also to lower the risk of complications and improve patient-centered health outcomes and patients' well-being.[22] Individuals with obesity may not be prepared to initiate the treatment. Therefore, health care providers should ask the patient's permission to discuss this issue.[23]

The first-line therapy of overweight / obesity is lifestyle modification comprising a balanced, energy-restricted diet (a mean daily deficit of 600 kcal, regardless of macronutrient composition) and increased physical activity. There is no consensus about the best nutritional approach to weight loss;[24] therefore, many dietary models that are safe, effective, nutritionally adequate, and affordable for long-term adherence may be used in obesity management.[25] Behavioral interventions are considered effective when they lead to a weight loss of 5% or greater.[23] Previous studies showed that a loss of the initial weight by 5% improves clinical outcomes.[26] On the other hand, the optimal weight loss rate should not exceed 0.5 to 1 kg per week.[23] All patients with excess body weight should receive individualized medical nutrition counseling provided by a registered dietitian and be educated about well-balanced eating patterns that focus on healthy food choices, meal portion decreasing, avoiding snacks between meals, not skipping breakfast, avoiding eating at night, and improving control over their food intake.[11,23] Practical dietary counseling should emphasize the need to increase the consumption of vegetables and whole-grain products as good sources of fiber, avoid foods containing added sugars and solid fats, as well as sugary drinks and alcohol-containing beverages. The nutritional recommendations should be personalized to meet the individual values, preferences, and treatment goals.[11,21]

Physical activity can lead to a mild loss of weight and fat (because of increasing energy expenditure), improvement of cardiometabolic parameters and health-related quality of life, and weight maintenance.[21,27] It is recommended to engage in regular aerobic activity (30–60 min of moderate- to vigorous-intensity exercise, most days of the week), preferably in combination with resistance training (for fat-free mass maintenance).[21] The type of exercise must be tailored to the patient's abilities and health status, and focus on a gradual but safe increase in intensity.[11] Previous studies showed that increasing exercise intensity (eg, high-intensity interval training) can enhance the level of cardiorespiratory fitness and reduce the time required to gain benefits similar to those conferred by moderate-intensity aerobic activity.[28] Similarly as with diet, patients should engage in the type of physical activity they can and wish to adhere to in the long term.

Psychological interventions Obesity, being a chronic disease, requires lifelong management. Therefore, apart from modification of diet or increasing the physical activity level, the therapy of obesity should also include multicomponent psychological and behavioral interventions, such as a combination of behavior modifications (goal-setting, self-monitoring, problem-solving), cognitive therapy, and values-based strategies to alter the dietary and physical activity habits.[21] Psychological assistance is recommended by the EASO in all individuals with previous treatment failure. It can also be a method supporting the treatment of patients with obesity. According to the EASO, cognitive-behavioral therapy should be incorporated into care plans for weight loss in the patients with mental problems or disorders.[11]

Unfortunately, as shown in previous long-term, observational studies, the effectiveness of non-pharmacological therapies in the treatment of obesity is lower than 10%, and these therapies are frequently followed by weight regain due to metabolic adaptation and low adherence to long-term lifestyle modifications.[29] Therefore, in most patients with advanced disease, it is necessary to use pharmacotherapy or perform a bariatric surgery.

Pharmacotherapy Pharmacological treatment is recommended to support the therapy of obesity

and overweight in all adult (≥18 years old) patients with a BMI greater than 30 kg/m^2 or those with a BMI greater than or equal to 27 kg/m^2 with at least 1 obesity-related comorbidity (prediabetes, T2DM, hypertension, dyslipidemia, obstructive sleep apnea). Pharmacological therapy should last at least 12 months, and its effectiveness can be confirmed by a reduction in the initial body weight by at least 5% over a 3-month period (when the drug was taken in a therapeutic dose). There are 3 substances registered for use in obesity treatment on the Polish market: orlistat (Xenical), naltrexone / bupropion (Mysimba), and liraglutide (glucagon-like peptide 1 [GLP-1] analog; Saxenda). Orlistat inhibits the activity of gastric and pancreatic lipase and, in consequence, impairs digestion and absorption of dietary fats (by about 30%). It does not affect the feeling of fullness and hunger. In a meta-analysis of studies on orlistat therapy (n = 22), the mean weight loss at 12 months was estimated at –2.89 kg (–3.51 to –2.27 kg).[30] Contraindications to the use of orlistat are hypersensitivity to the active substance, simultaneous treatment with cyclosporine or warfarin (and other oral anticoagulants), chronic malabsorption syndrome, cholestasis, pregnancy, and breastfeeding.[31] Bupropion / naltrexone combines 2 substances that had already been approved for use in other diseases. Bupropion is a nonselective inhibitor of dopamine and norepinephrine transporters and is used for the treatment of depression and nicotinism. Naltrexone is an opioid receptor antagonist used to treat alcohol and opiate addictions. In patients with obesity, the anorectic effect (activation of POMC neurons and cocaine amphetamine-regulated transcript in the arcuate nucleus of the hypothalamus) of bupropion, potentiated by naltrexone, allows for reduction of food intake and, consequently, weight loss (mean, 5 kg).[32] Moreover, the naltrexone / bupropion combination affects the mesolimbic reward system and suppress the appetite.[12] The main adverse effects of bupropion / naltrexone are nausea, headache, constipation, dizziness, vomiting, and xerostomia. Contraindications include pregnancy, uncontrolled hypertension, seizure, anorexia or bulimia nervosa, as well as abrupt discontinuation of alcohol and drugs, such as benzodiazepines, barbiturates, or antiepileptic drugs, other bupropion-containing drugs, opioids, opiate agonists, or monoamine oxidase inhibitors.[31,33] Liraglutide is a GLP-1 agonist approved in 2010 for the treatment of T2DM (in a dose of 1.8 mg/d). A higher dose (3.0 mg/d subcutaneously) of liraglutide was approved for obesity treatment by the Food and Drug Administration (FDA) in 2014 and the European Medicines Agency in 2015.[31] Liragultide lowers the body weight (mainly visceral fat), reduces the feeling of hunger and desire to eat, slows down gastric emptying, and induces post-prandial satiety and fullness.[34] A 12-month liraglutide therapy results in an average weight reduction of 8.4 kg.[35-38] Liraglutide is generally well tolerated, but possible side effects, such as nausea, vomiting, diarrhea, constipation, and dyspepsia may occur during the treatment. Contraindications to using liraglutide include hypersensitivity to the drug or any of the excipients, pregnancy, and breastfeeding.[31]

New antiobesity drugs have been developed and studied in clinical trials over the last few years. A meta-analysis by Zhong et al[39] showed that semaglutide (a GLP-1 receptor agonist) is safe, well tolerated, and effective in body mass reduction, and significantly improves cardio-metabolic outcomes and health-related quality of life.[39] Recently published data concerning tirzepatide showed that this novel dual glucose-dependent insulinotropic polypeptide / GLP-1 receptor agonist not only positively influences the β-cell function and glycemic control but may also be useful in obesity therapy. In the SURMOUNT-1 clinical trial,[40] 5 mg, 10 mg, or 15 mg of tirzepatide once weekly had a significant, dose-dependent (15%–20.9% of the initial weight), and sustained effect on body weight reduction. Both semaglutide and tirzepatide received an FDA approval but have not been approved for the treatment of obesity in Poland.

Pharmacological therapy should always be considered in combination with diet and physical activity modifications. Drug taking does not nullify the need for adherence to comprehensive non-pharmacological therapy. The patient should be reminded about this during each visit, and compliance should be verified.

Bariatric surgery In holistic obesity management, bariatric surgery should be considered in adults (18–65 years old) with a BMI greater than or equal to 40 kg/m^2 or those with a BMI greater than or equal to 35 kg/m^2 with at least 1 obesity-related disease. It has also been recommended to consider bariatric treatment in patients with class I obesity (BMI 30–35 kg/m^2) and poorly controlled T2DM (to achieve remission) and / or those in whom optimal medical and behavioral therapy has been insufficient to induce significant weight loss.[41,42] The choice of a type of bariatric procedure should be made based on the patient's need, in collaboration with an experienced multidisciplinary team.[43] Before the surgical treatment, the patient should undergo a psychological evaluation and receive nutritional and physiotherapeutic counseling.[44] It should be emphasized that bariatric surgery is not a way to directly reduce the body weight, but that it introduces alterations in the anatomy of the digestive tract that lead to beneficial changes in the neurohormonal regulation of food intake and energy expenditure.

Multidisciplinary approach Due to the high prevalence, serious health consequences, and psychosocial and economic burden, obesity requires special attention and cooperation in many fields, not only with respect to medical treatment but also the management of lifestyle and psychological factors. The obesity treatment should be systemic

and carried out by a multidisciplinary therapeutic team consisting of a doctor, nurse, dietitian, psychologist or physiotherapist, and surgeon. All health care providers involved in the care of patients with obesity should actively support them at every stage of the therapy and during implementation of the lifestyle changes. In the management of obesity, all possible treatment options based on the best available evidence should be considered. In the presence of indications, they should be implemented to achieve the individual therapeutic goals. Not recommending effective therapeutic methods, including pharmacotherapy or, in the most advanced cases, bariatric surgery, to patients developing obesity complications should be judged as omission.

It should be emphasized that, on average, more than 50% of the weight loss achieved due to lifestyle interventions is regained after 2 years and more than 75% is regained after 5 years.[45] A small percentage of weight regain can also occur after bariatric surgery,[46,47] but it can be prevented by pharmacotherapy.[48] The weight regain is challenging for health care providers not only in terms of formulating therapeutic recommendations but also supporting the patients throughout the treatment process, especially during the relapse phases.

The success of obesity therapy may be influenced not only by the type and intensity of nonpharmacological, pharmacological, or surgical treatment and relapse prevention, but also by an effective relationship between the therapeutic team and the patient. A good therapeutic relationship is conducive to determining the causes of obesity and choosing the appropriate therapeutic methods, but above all, it increases the patient's compliance.

Doctor-patient relationship Scientific research confirms that a good rapport between a doctor and a patient favors patient adherence to therapy and compliance with the recommendations, and reduces the risk of relapse.[49] The nature of the therapeutic relationship is determined by many components, including the attitude of the patient but also that of the doctor. In some cases, the attitude toward a certain group of patients may, often unconsciously, be influenced by social stereotypes. This often happens with respect to patients with excess body weight—they are considered to show negative traits, such as laziness, self-indulgence, lack of motivation, self-discipline, and self-control, weak willpower, inconsistency, sloppiness, and even lack of intelligence.[50]

Research shows that the medical community is not free from prejudices, and even describes cases of discriminatory behavior toward patients with obesity.[51] Doctors often display strong skepticism about the motivation and self-discipline of the patients with excess body weight and see these features as the main obstacles to the effective treatment of obesity. This may influence their passive attitude when treating this disease and lead to shifting the responsibility for weight loss solely to the patients.[52,53] Data show that family doctors, who have the first and most frequent contact with people with obesity, differ in their attitude toward this group of patients. Depending on how they perceive their role in obesity treatment, the following types can be distinguished: sceptic (characterized by a negative attitude toward obesity treatment and a lack of willingness to care), instructor (emphasizes the value of active exercise, diet, and health promotion), motivator (perceives psychosocial support and motivation as the key elements of helping the patients), and educator (focuses primarily on early prevention through the patient education).[54]

Basically, evidence shows that general practitioners devote less time to the patients with obesity than to those with normal body weight, more often consider the meeting a waste of time, and more often associate the patient's health problems only with obesity, without undertaking further diagnostics and treatment.[55] The patients with obesity are also often treated with less respect than individuals with normal body weight.[56] Already medical students show hidden, and sometimes also overt, prejudice against patients with obesity. These prejudices are stronger than those against homosexual people and are more often manifested by men and individuals with a lower BMI.[57] Also in a Polish study[58] most doctors declared that worse attitude toward patients with obesity was a common phenomenon. Approximately 48% of the respondents witnessed a discriminatory behavior of the medical personnel. The most common forms of misbehavior were related to personal interactions and included mocking the patient's appearance, looking at the patient with disgust, not responding to offensive remarks made by others, or threatening the patient with negative consequences if they do not lose weight. The participants of the study pointed out a difficult access to dedicated medical equipment as a discriminatory limitations of the health care system.[58]

Stigma of obesity Adverse or harmful actions toward people with obesity, labeling them with negative traits and behaviors, and disgracing them in public are referred to as stigmatization of obesity. It is a widespread phenomenon in developed countries,[59] despite a large number of people with obesity.[60] Much of the stigma comes from placing the responsibility for the disease on the individual. Obesity is seen as highly controlled and provoked by the patient through certain behaviors or negligence. Also, the reduction of excess body weight is treated as a task that the patient should deal with on their own. Thus, stigmatization of obesity is seen as a justified and accepted social response.[61]

Satisfaction with one's own appearance is an important predictor of well-being, especially in women. All visible body defects, but most of all, a subjective attitude toward them, can affect

the psychosocial functioning. A Polish study involving women with obesity or psoriasis and a control group showed that the subjective assessment of one's own body and attitude toward it influenced the perceived stigma, regardless of the condition causing the stigma and the objective appearance of the participant. At the same time, body weight was a strong predictor of the level of the perceived stigma, and women with obesity experienced the highest levels of stigma among the compared groups.[62]

Stigmatization of people with obesity is associated with reduced compassion and willingness to help, as well as feelings of dislike and even anger toward this group of patients. This results in manifestations of discrimination in social life, for example, in the workplace, educational institutions, mass media, health care institutions, and even in close interpersonal relationships.[63] The consequences of stigmatization are deteriorated mental health of people with obesity, as well as related issues, for example, high levels of stress and anxiety, reduced quality of life, abuse of psychoactive substances, negative body image, reduced self-esteem, or eating disorders.[64,65] The stigma of obesity can also cause or exacerbate depressive symptoms. Obesity often coexists with depression, and the diseases affect each other.[66] Moreover, both of them can be the reason for stigmatization, and when combined, the effects are intensified.[67] Therefore, antidepressive treatment should always be considered in patients with obesity. The most commonly used antidepressants are citalopram, fluoxetine, sertraline, amitriptyline, and mirtazapine. However, long-term (>12 months) pharmacotherapy with antidepressants, especially with several agents used simultaneously, requires a clinical review to consider the balance of risks and benefits due to the increased risk of some side effects in this group of patients. Other antidepressive treatments, such as psychotherapy, may also be beneficial.[68]

Obesity stigma positively correlates with poorer physical health, avoidance of health care leading to worsening of medical problems, unhealthy eating behaviors and decreased physical activity, increased levels of cortisol, oxidative stress, and C-reactive protein, and increased risk of diabetes.[69] Paradoxically, the stigmatization of obesity also has long-term consequences in the form of excessive weight gain and worsening of obesity-related problems.[70] Moreover, it has negative effects at the public health level. These include reduced and inadequate use of health care, disregard for the social and environmental factors leading to obesity, impairment of obesity prevention efforts, and widening of health and social inequalities among citizens.[71]

Taking into account the prevalence of stigmatization of patients with obesity and its negative consequences for mental, physical, and public health, an interdisciplinary group of international experts, including representatives of 10 scientific organizations, developed a common position statement against the stigmatization of people with obesity, along with recommendations on social relationships and communication in this regard. The experts opposed the use of stigmatizing language, images, attitudes, and rules, as well as weight-based discrimination, wherever they occur. They encouraged educational measures and initiatives to prevent discrimination on the basis of the body weight in the workplace, as well as in education and health care institutions.[72]

Patient-centered care What kind of activities can be undertaken in medical practice to prevent stigmatization and discrimination of patients with obesity? At this point, we would like to focus on 2 issues, namely, the relationship and communication with the patients. The interpersonal relationship based on the assumptions that the patient is a subject in the treatment process and that their well-being is the main point of reference for all interventions is the essence of the approach defined as patient-centered care. In the patient-centered care model proposed by the National Academy of Medicine, 6 aspects are distinguished: 1) respect for the values, choices, and needs important to the patient, 2) coordination and integration of care, 3) information, communication, and education, 4) physical comfort, 5) emotional support and reducing fear and anxiety, 6) involvement of family and relatives.[72] Researchers emphasize that the patient-centered approach is of key importance for the quality of care[73] and has a positive effect on the patients' satisfaction, self-management,[74] and self-care.[75] A systematic review[76] analyzing studies on the impact of patient-centered care on individuals with chronic heart failure also pointed out benefits conferred by this model, associated with better physical and mental state of the patients, lower costs of care, reduced sense of uncertainty, and, with respect to symptom burden, greater self-efficacy.[76] The positive impact of patient-centered care has been confirmed in oncological patients.[77] Also, individuals associated in the International Alliance of Patients' Organizations drew attention to the benefits of patient-centered health care. In the Declaration on Patient-Centered Healthcare, they emphasized that this type of care is the most equitable and cost-effective.[78]

In practice, patient-centered care is primarily a style of communication used by the medical personnel. It is expressed both by taking into account the patient's perspective and by avoiding terms that may stigmatize or lead to a stereotypical view of the patient's situation. To consider the patient's perspective, it is required, first and foremost, to ask questions that allow the care giver to hear how the patient views their health. Another important aspect is using paraphrases and reflections that build up the patient's feeling of being heard and understood and allow the clinician to make sure that they see the key aspects

of the patient's situation. Communication is not only a carrier of attitudes and beliefs but it also shapes reality.

Professional communication is a tool for creating effective therapeutic relationships and implementing patient-centered care. It also prevents the obesity stigma mentioned above. The benefits of effective communication between the doctor and the patient are multidimensional. They are related to issues such as follow-up diagnostic testing and prevention of serious diseases,[79] more accurate diagnosis and adequate treatment,[80] patient's satisfaction with the visit and understanding of the message,[81] medical adherence,[82] better long-term treatment effects,[83] induction of the placebo and nocebo effects,[84] better cooperation of the therapeutic team,[85] reduced risk of medical errors,[86] and lower risk of lawsuits filed by patients against doctors.[79] Communication with a patient with obesity should consider the importance of psychological factors in the development, maintenance, and treatment of this disease.

For this reason, it is worth talking about obesity according to the principles of "people-first language." This approach is considered the standard in speaking respectfully about people with chronic diseases and disabilities. It is also used in materials and publications produced by the Obesity Society.[87] Such an approach allows for talking about and addressing people with obesity and other diseases with respect and dignity, which are values that underpin both patient-centered care and medical professionalism in the broad sense.

Patient-centered care and the "people-first language" in obesity management From a practical point of view, application of the principles described above is primarily based on speaking in such a way as to firstly indicate not a symptom, but a person (ie, "a patient suffering from obesity" or "a patient with obesity," and not "an obese patient," a "fat," "stout," or "fluffy" person). There is no need to speak about the patients' problems euphemistically (eg, "big-boned") or evaluate them (eg, "you are too fat, plump"). Instead, it is better to use medical terms such as "obesity," "overweight," and "excess body mass." Treatment of obesity is based on therapeutic activities related to the disease, not on losing weight or, as often said colloquially, "doing something with oneself." Such an attitude suggests that obesity is a consequence of a patient's character traits or behaviors that are controlled by them, and that the patient is fully responsible for their condition. When examining a patient with obesity, it is important to use professional terminology describing medical activities (ie, "body mass," "body composition," or "waist circumference measurement") instead of colloquial terms (eg, "weighing," "checking whether the patient has made progress" or "slimmed down").

In order to make a diagnosis and formulate recommendations for the patient, it is crucial to know their perspective. It is important not to force one's own or common beliefs or ideas about the patient's situation. The patient's activities related to excess body weight so far and the perception of this issue can be asked about, for example, in the following way: *What led to the fact that you weigh XX kg*? *Have you ever tried to change your weight*? *What do you think are the reasons you weigh XX kg*? *Do you see your weight as a problem*? When talking to the patient about recommendations that include lifestyle changes, it is worth referring to their readiness and ability to implement such changes. This can be done by asking questions that are also thought-provoking, for example: *Do you see a possibility to limit the consumption of sugar-containing products*? *How could you do this, given your daily life*? *What do you think could help you implement the recommendations we discussed*? *Could I explain or do something that could help you*? Such an approach makes the patient feel that they can shape their treatment effects. It also shows that the doctor understands that any changes in the patient's lifestyle depend on their readiness and determination to introduce these changes. Such an approach increases the likelihood of adherence and improves the therapy effectiveness.

The main principles of the "people-first language" approach, such as emphasizing that the subject of the discussion is a person, and not his or her traits, disease, or disability, should be known to doctors and be a part of the education program on communication skills and professionalism during university and postgraduate studies. This approach promotes the use of nonstigmatizing phrases that put the patient first. It also influences the way the health care providers think about the patients and presents them as individuals struggling with a specific situation. In a broader perspective, it may lead to changes in social awareness and reduction of stigmatization, as well as building a doctor-patient relationship that improves the effectiveness of the treatment.

Conclusions Individuals with obesity constitute a large patient poulation, both in the practice of family doctors and in specialist care. The situation of these patients is influenced by many factors. These include available therapies and psychosocial determinants, as well as the attitude of the medical staff and their communication skills. The stigma of obesity also occurs in medical care facilities and manifests, among others, in exclusive language that contributes to worsening of the health state and psychosocial functioning of the patients. That is why patient-centered care and the "people-first language" approach are so important. They restore dignity to patients with obesity, encourage them to adhere to the therapy, and promote effective obesity management. An approach including these principles should be applied in the everyday care of patients with obesity and the education of medical staff.

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