Taylor, A., and Ogden, J. (2009). Avoiding the term 'obesity': an experimental study of the impact of doctors' language on patients' beliefs. Patient Education and Counselling, 76; 260-274.

Avoiding the term 'obesity': an experimental study of the impact of doctors'

language on patients' beliefs

Anisha Taylor and Jane Ogden

Department of Psychology, University of Surrey, Guildford, Surrey

Correspondence to:

Jane Ogden

Professor in Health Psychology

Department of Psychology

University of Surrey

Guildford

GU2 7XH

UK

Email: J.Ogden@surrey.ac.uk

Abstract

Objectives: GPs sometimes use euphemisms rather than medical terms. The present study aimed to explore the relative impact of using the term ‘obese’ compared to GPs’ preferred euphemism on patients’ beliefs about the problem. **Methods:** A cross sectional survey followed by an experimental study was used with two conditions: the term ‘obese’ vs the GPs’ preferred euphemism. In the cross sectional survey, GPs’ (n=19) described their preferred use of term. In the experimental study, patients (n=449) from one General Practice in West London then completed a set of ratings about their beliefs following a vignette using either the term ‘obese’ or the GPs’ preferred euphemism. **Results:** The first stage of the study showed that GPs avoided using the term ‘obese’ and preferred to use a euphemism. The most commonly used euphemism was ‘your weight may be damaging your health’. The second stage showed that the term ‘obese’ made patients believe that the problem had more serious consequences and made them feel more anxious and upset than when the same symptoms were labelled using the euphemism. When analysed according to the patient’s own BMI, however, the results showed that the term ‘obese’ had a greater emotional impact than the euphemism only on patients who were not obese; obese patients found the euphemism more upsetting. **Conclusion:** GPs avoid using the term ‘obese’ for fear of upsetting patients. This term, whilst making the problem appear more serious is only more upsetting for non obese patients. **Practice Implications:** GPs choice of term therefore needs to reflect whether they want the patients to be upset or whether they want them to accept the seriousness of their problem.

Key words: consultation; communication, language; euphemisms; obesity

1. Introduction

The current emphasis in primary care is one of openness and shared decision-making [1-5]. General Practitioners (GPs) are also encouraged to respect patients' feelings [1-7]. These perspectives sometimes present GPs with a dilemma regarding their choice of language as the same term may have a conflicting impact on the patient. For example, using a medical term may facilitate patient involvement in decision-making but at the same time may create feelings of anxiety and worry. To avoid such negative feelings doctors sometimes use euphemisms, which are perceived as less emotive. In turn, however, such euphemisms may be considered to be less open.

Recent research has explored doctors' use of language and how their choice about which term to use can impact upon patients' perceptions of a medical problem. For example, Ogden et al. [8] used an experimental design to assess the impact of presenting patients with either a lay diagnosis (e.g. stomach upset) or a medical diagnosis (e.g. gastroenteritis). They concluded that patients found the medical term more beneficial, as it improved their confidence in the doctor and made them feel that their problem had been taken seriously. Conversely, the lay term made patients feel greater ownership of the problem and a higher sense of blame. Another experimental study explored GPs' use of the term 'heart failure' compared to their preferred euphemism 'you have fluid on your lungs as your heart is not pumping properly' [9]. The results showed that compared to the euphemism the medical term made patients feel more anxious and upset and made them believe that the problem had more serious consequences and would last longer.

The language used by the doctor may therefore influence **how patients feel about their problem**. In line with this, the present study focused on the use of the term ‘obese’ in the consultation. Research indicates that obesity is a highly stigmatised problem [10] associated with blame and personal responsibility [11]. A study by Blixen et al. [12] also found that the word ‘obese’ was considered to be ‘vulgar’ and connotative of unattractiveness. This suggests that doctors may choose to avoid the medical term for fear of upsetting patients with its negative associations. The present research consisted of two studies. The first examined whether GPs tend to use or avoid the term ‘obese’ and to identify their preferred euphemism and the second aimed to determine the relative impact of the medical term versus the GPs’ preferred euphemism on patients’ beliefs about the problem. This experimental study drew upon the self-regulatory model developed by Leventhal [13]. This model suggests that patients develop illness cognitions about their problem which are consistent across a number of different diagnoses including diabetes, heart disease, chronic fatigue syndrome and obesity. The model also argues that these cognitions are made up of five core dimensions which are the nature and identity of the problem, its timeline, its potential consequences on their life, whether it is controllable by either treatment or themselves and the possible causes. Much research had explored these dimensions and indicates that they relate to the ways in which patients subsequently cope with and adjust to the problem.

Study 1: GPs’ use of euphemisms

2. Method

2.1. Design

A small scale cross sectional survey was used to establish the likelihood of GPs using the term ‘obese’ or a range of possible euphemisms.

2.2. Measures

Twenty three GPs were presented with the following vignette via email: ‘If you had a patient who had a BMI over 30, which *one* of the following terms would you be most likely to use *to the patient?*’ GPs had to choose from eight phrases, which consisted of two medical terms and six euphemisms generated by the researcher through discussions with GPs. The terms were: ‘You are heavier than you should be’; ‘You are overweight’; ‘You are too fat’; ‘You need to lose some weight’; ‘You are an unhealthy weight’; ‘Your weight may be damaging your health’; ‘You are obese’, and ‘You are suffering from obesity’. The doctors were also asked to give details of their age, sex and whether they worked full-time or part-time. Responses were received from 19 GPs (response rate = 82.6%). These GPs were selected from 23 different practices and were chosen to offer a heterogenous sample in terms of GP’s demographic characteristics and location of practice.

3. Results of Study 1

The GPs’ data were analysed to describe their profile characteristics, to compare their relative preferences for the euphemisms and the medical terms, and to determine which euphemism was most favoured by the GPs.

3.1. Profile characteristics of GPs

Of the 19 GPs, the majority were male (n=12, 63%), full-time (n=12, 63%) and either aged between 40 and 49 (n=8, 42%) or 50 and 60 (n=8, 42%).

3.2. GPs' use of terms

The GPs' preferences for the different terms are shown in Table 1.

-insert Table 1 about here -.

The results showed that the GPs avoided the term 'obese' and that the most popular term was the euphemism 'your weight may be damaging your health', followed by 'you are overweight' and then 'you need to lose some weight'. The least popular terms were 'you are an unhealthy weight' and 'you are too fat' which were not chosen by any of the doctors. The GPs' preference for the term 'you are obese' was equal to their preferences for 'you are suffering from obesity' and 'you are heavier than you should be'. The results indicated that the majority of the GPs would prefer to use a euphemism rather than the term 'obese' in a consultation.

Study 2: The impact of the term 'obese' versus the favoured euphemism on patients' beliefs about the problem

2. Method

2.1. Design

An experimental design with two conditions was used with patients rating their responses to a vignette containing either the term 'obese' or the preferred euphemism 'your weight may be damaging your health'. The vignette was placed at the start of the questionnaires which were then distributed to patients to randomize which vignette they received.

2.2. Sample

In total, 615 consecutive patients aged over 18 visiting one practice in South West London were asked to complete a questionnaire. The practice is situated in an inner city district with a total of 9200 patients. Patients were excluded if they were not deemed well enough to complete the questionnaire. A sample size calculation was made using data from a similar previous experimental study based on responses to Likert scales [8] which indicated that 200 patients in each group would be sufficient to detect a significant difference in beliefs between the two conditions. Of the 615 patients approached, 472 patients collected a questionnaire and 455 returned the questionnaire. Of the returned questionnaires, six were unusable because a high number of items on the illness beliefs scale were not completed (response rate = 73.0%).

2.3. Measures

Patients were asked to read the following vignette: ‘Imagine that you are a patient who is experiencing joint pain and breathlessness. Your doctor weighs you and tells you that EITHER ‘you are obese’ or ‘your weight may be damaging your health’.

Patients were then asked to rate a series of items to describe their beliefs about their problem. These items were derived from the Revised Illness Perception Questionnaire (IPQ-R) [14] and rated using a 5 point Likert scale ranging from ‘not at all’ (1) to ‘totally’ (5). This is a valid quantitative measure which assesses how individuals make sense of an illness. It is based on the components of illness representations described in the Self-Regulation Model and has been used extensively in research exploring patients’ beliefs across a number of different conditions [13,14].

The original questionnaire consists of 8 subscales. For this study seven subscales were selected to examine patients’ beliefs about the problem in terms of the following

core domains which have been used in previous work to explore the impact of euphemisms [9]. The scale relating to identity was not included as this describes a number of symptoms, many of which are not related to obesity. Reliability was assessed using Cronbach's alpha. The subscales were: patient understanding (e.g. your problem doesn't make any sense to you; $\alpha = 0.55$), consequences (e.g. your problem will have major consequences on your life; $\alpha = 0.63$), personal control (e.g. your actions will have no effect on the outcome of your problem; $\alpha = 0.48$), emotional impact (e.g. you will get depressed when you think about your problem; $\alpha = 0.78$), treatment control (e.g. your treatment can control your problem; $\alpha = 0.71$), cyclical timeline (e.g. you will go through cycles in which your problem will get better and worse; $\alpha = 0.63$) and timeline (e.g. your problem will pass quickly; $r = 0.26$). To simplify the questionnaire the number of items in each subscale was reduced to three based on published reliability data by selecting those items with the highest factor loadings in the original psychometric paper [14]. The exception for this was the timeline domain which was measured using two items as respondents commented in the pilot study that questions in this subscale were too repetitive. In addition, three items reflecting trust in the doctor (e.g. this diagnosis reassures you that the doctor knows what's wrong; $\alpha = 0.79$) were included in the scale. **This subscale has been used in previous research and has been found to be influenced by choice of term [8].** The data were analysed by summing the items into the eight subscales.

Patients were also asked to describe their age, sex, ethnicity, level of education, present weight and height (in order to calculate BMI) and how frequently they had visited their doctor in the past year. Patients were also asked whether or not they knew

somebody who was obese and whether or not they knew somebody whose weight might be damaging their health.

2.4. Data analysis

The data were analysed to describe patients' profile characteristics and to assess the relative impact of the term 'obese' versus the GPs' preferred euphemism on patients' beliefs about the problem. Finally the role of the patient's own BMI was also assessed.

3. Results from Study 2

3.1. Patients' profile characteristics

Patients' profile characteristics are shown in Table 2.

-insert Table 2 about here -

The patients' mean age was 43.32 yrs and the majority of patients were females, white, college educated and had visited their doctor up to seven times in the past year and 19.2% of patients were obese. Half knew someone who was obese and just over half knew someone whose weight was damaging their weight. In terms of differences between the experimental groups the two groups differed in terms of age however there were no other differences between the groups. Age was used as a covariate in subsequent analyses.

3.2. The impact of the term 'obese' versus the preferred euphemism on patients' beliefs about the problem

A one-way between-groups multivariate analysis of covariance was conducted to examine the relative impact of the term 'obese' versus the euphemism on patients'

beliefs about the problem whilst controlling for age. Patients' beliefs about the problem in relation to the eight domains are shown in Table 3.

-insert Table 3 about here -.

The results showed that being told 'you are obese' was associated with the patients believing that the problem had more serious consequences and would have a greater emotional impact than being told 'your weight may be damaging your health'. The two terms did not differ significantly in their impact on patients' understanding of the problem, their trust in the doctor, their personal ability to control the problem, the timeline of the problem, the likelihood that treatment could control the problem and the cyclical timeline of the problem.

3.3. The impact of the term 'obese' versus the preferred euphemism and of BMI on patients' beliefs about the problem

Patients were divided into two groups according to their BMI; those with a BMI lower than 30 were categorised as not obese ($n = 273$) and those with a BMI greater than or equal to 30 were categorised as obese ($n = 65$). A two-way between-groups multivariate analysis of covariance was conducted to explore the impact of the term used and of BMI on patients' beliefs about the problem whilst controlling for age. The results showed a significant interaction between the term used and BMI group on patients' beliefs about the emotional impact of the problem: ($F(1, 289) = 8.07, p = 0.005$; CI of difference: lower = 0.27, upper = 1.49). Patients who were not obese felt more anxious and depressed when the term 'obese' was used ($M = 3.87, SD = 0.91$) compared to when the euphemism was used ($M = 3.30, SD = 1.15$). In contrast, obese people felt more anxious and depressed when the euphemism was used

($M=3.67$, $SD = 0.97$) compared to when the term ‘obese’ was used ($M = 3.37$, $SD=1.27$). No other interactions were found.

4. Discussion

4.1 Discussion

The results showed that the majority of GPs avoided using the term ‘obese’ and favoured a euphemism. Their most preferred euphemism was ‘your weight may be damaging your health’. This supports previous research which suggests that the term ‘obese’ has negative associations relating to discrimination and blame [10,11] and is in line with a recent study indicating that GPs also avoid of the term ‘heart failure’ and similarly prefer to use a euphemism [8].

The results also showed that the term ‘obese’ made patients believe that the problem had more serious consequences and made them feel more anxious and upset than when the same symptoms were labelled using the euphemism. Previous research indicates that language selection in consultations may influence patients’ beliefs about an illness [8,9] and the results from this study provide further evidence to support this.

When BMI was accounted for, however, the results showed that the term ‘obese’ only had a greater emotional impact than the euphemism on patients who were not obese; obese patients found the euphemism rather than the term ‘obese’ more upsetting. These results conflict with suggestions that the term ‘obese’ may be too emotive because it has negative connotations. The results, however, are consistent with those of Ogden et al. [9] who reported that patients found medical terms more beneficial, in terms of feeling that they deserved sympathy and had not brought the problem upon

themselves. It is possible that obese patients feel less upset by the term 'obese' because it implies that the problem is something that has happened to them rather than something that they have caused and could be personally blamed for.

There are some problems with the present study that should be considered. Firstly, the design was based on a hypothetical vignette rather than a real interaction between the doctor and patient. Although vignettes are frequently used in primary care research [eg. 8,9] it is possible that patients respond differently to hypothetical scenarios compared with face-to-face consultations. Additionally, the study aimed to assess the impact of the use of one term ('obese') in isolation from the impact of another term (euphemism). In a real consultation it is possible that the doctor may use both phrases, perhaps 'obese' to diagnose the problem and a euphemism to explain it to the patient. In addition, it is possible that many other factors could influence the impact of the words used in a consultation such as the patient's concern about their weight rather than just their weight status, the patient's general health status and the existence of other weight related problems such as diabetes or heart disease and the doctors own demographics such as their gender or own body weight. The design, therefore, does not account for the complex nature of the interaction between patient and doctor. Thirdly, the study was based in only one General Practice and responses may have reflected the usual care the patients receive from the doctors at this practice. Nevertheless, this experimental approach enabled all other aspects of the consultation to be kept constant so that the impact of each phrase could be examined individually. Thus, the design enabled an experimental and quantitative investigation of an area often only studied through observation.

4.2. Conclusion

The results show that GPs avoid using the term ‘obese’ and prefer to use a euphemism. Their preferred euphemism was ‘your weight may be damaging your health’. The results also show that the term ‘obese’ and their preferred euphemism have a different impact upon the patient’s understanding of the problem. In particular, whilst the term ‘obese’ made the problem appear more serious it was less upsetting than the euphemism for patients who are obese.

4.3. Practical implications

In recent years, there has been a shift towards openness and shared decision-making in primary care [5-7]. Additionally, GPs have been encouraged to take the patient’s feelings into consideration [2,7]. The results from the present study suggest that for patients who are obese, the term ‘obese’ may allow GPs to share their expertise and knowledge without compromising the patients’ feelings. Thus, using the medical term may enable doctors to attain both of these aims at the same time. However, GPs’ language choice may also be influenced by what they believe will promote beneficial health behaviours and encourage compliance with advice. Research exploring links between information, language and behaviour change at present remains equivocal (see 15, 16 for comprehensive reviews). For example, research indicates that messages that arouse fear are not sufficient to change subsequent behaviour. However, research also indicates that some degree of perceived threat and a perception of severity are needed if behaviour change is to occur. Furthermore, a high emotional response to a message can result in denial and may even encourage the unhealthy behaviour that the message is trying to prevent. This contradictory research presents a dilemma for the GP. The GP may wish to avoid a negative emotional

response by using the term 'obese' for obese patients. This could prevent a process of denial and may enable the obese person to engage with behaviour change.

Furthermore, for some patients, believing that the problem is serious may encourage behaviour change, suggesting that the medical term would also be favourable. For other patients, however, a negative emotional response may be required to trigger efforts to improve their health, indicating that using a euphemism would be more beneficial. This suggests that it is up to the doctor to decide which will be more beneficial in the long term; making the patient feel anxious or making him or her believe the problem is serious. Further research is needed exploring the direct links between language used and behaviour before any universal rules about the doctor's use of language can be made.

Funding body: None.

Ethics committee: Surrey Research Ethics Committee.

Conflict of interest: None

Acknowledgements: The authors are grateful to the GPs and patients who took part in this study.

References

- [1] Pendleton D, Schofield T, Tate P, Havelock P. The consultation: an approach to learning and teaching. Oxford: Oxford Medical Publications, 1984.
- [2] Tuckett D, Boulton M, Olson C, Williams A. Meetings between experts. London: Tavistock Publications, 1995.
- [3] Levenstein JH, McCracken EC, McWhinney IR, Stewart MA, Brown JB. The patient centred clinical method. Part 1. A model for the doctor patient interaction in family medicine. *Fam Pract* 1996;3:24–30.
- [4] McWhinney IR. Why we need a new clinical method. London: Sage Publication, 1995.
- [5] Coulter A. Paternalism or partnership? Patients have grown up and there's no going back. *Br Med J* 1999;319:719–20.
- [6] Mead N, Bower P. Patient centredness: a conceptual framework and review of the empirical literature. *Soc Sci Med* 2000;51:1087–110.
- [7] Guadagnoli E, Ward P. Patient participation in decision making. *Soc Sci Med* 1998;47:329–39.
- [8] Ogden J, Branson R, Bryett A, Campbell A, Febles A, Ferguson I, Lavender H, Mizan J, Simpson R, Tayler M. What's in a name? Patient views of the impact and function of a diagnosis. *Fam Pract* 2003;20:248–53.
- [9] Tayler M, Ogden J. Doctors' use of euphemisms and their impact on patients' beliefs about health: an experimental study of heart failure.
- [10] Puhl R, Brownell K. Bias, discrimination, and obesity. *Obes Res* 2001;9:788-805
- [11] Ogden J, Bandara I, Cohen H, Farmer D, Hardie J, Minas H, Moore J, Qureshi S, Walter F, Whitehead M. GPs' and patients' models of obesity: whose problem is it anyway? *Patient Educ Counsell* 2001;40:227–233.
- [12] Blixen C, Singh A, Thacker H. Values and beliefs about obesity and weight reduction among African American and Caucasian women. *J Transcult Nurs* 2006;17:290-7.
- [13] Leventhal H, Meyer D, Nerenz D. The common sense representation of illness danger. *Med Psychol*; 1980.
- [14] Moss-Morris R, Weinman J, Petrie KJ, Horne R, Cameron LD, Buick D. The revised illness perception questionnaire (IPQ-R). *Psych Health* 2002;17:1–16.
- [15] Bennett, P., & Murphy, S. Psychology and health promotion. Open University Press: 1997.
- [16] Boer, H., & Seydel, ER. Protection Motivation Theory. In: M Conner and P. Norman. Predicting health behaviour. 2nd Edition. 2003.

Table 1: GPs' preferred terms when discussing problem with patient

Preferred phrase	Frequency	Percent
Your weight may be damaging your health	9	47
You are overweight	4	21
You need to lose some weight	3	16
You are suffering from obesity	1	5
You are obese	1	5
You are heavier than you should be	1	5
You are an unhealthy weight	0	
You are too fat	0	

Table 2. Patients' profile characteristics

	Total sample (n=449)	Told 'obese' (n=184)	Told 'euphemism' (n=171)	χ^2 / t
Age	43.32yrs ± 15.78	41.63 $\pm$ 14.88	45.04 $\pm$ 16.51	$t = -2.20$
Sex				
Male	147 (43.9%)	73 (33.2%)	74 (34.7%)	$\chi^2 = 0.12$
Female	286 (66.1%)	147 (66.8%)	139 (65.3%)	
Ethnicity				
White	233 (57.4%)	118 (57.6%)	115 (57.2%)	$\chi^2 = 0.01$
Other	173 (42.6%)	87 (42.4%)	86 (42.8%)	
Education				
Secondary school or less	102 (26.4%)	49 (24.9%)	53 (27.9%)	$\chi^2 = 0.66$
College	160 (41.3%)	85 (43.1%)	75 (39.5%)	
Undergrad or higher	125 (32.3%)	63 (32%)	62 (32.6%)	
Annual visits to doctor				
0-3	140 (34.1%)	75 (36.2%)	65 (31.9%)	$\chi^2 = 0.87$
4 +	271 (65.9%)	132 (63.8%)	139 (68.1%)	
Knows somebody who is obese				
Yes	209 (50.9%)	107 (52.2%)	102 (49.5%)	$\chi^2 = 0.30$
No	202 (49.1%)	98 (47.8%)	104 (50.5%)	
Knows somebody whose weight may be damaging their health				
Yes	138 (42.1%)	125 (61.0%)	113 (54.9%)	$\chi^2 = 1.58$
No	173 (57.9%)	80 (39.0%)	93 (45.1%)	
BMI	25.73 + 5.52	25.33 $\pm$ 5.92	26.15 $\pm$ 5.05	$t = -1.38$
BMI group				
Not obese (less than 30)	173 (80.8%)	144 (83.7%)	129 (77.7%)	$\chi^2 = 1.96$
Obese (30 +)	65 (19.2%)	28 (16.3%)	37 (22.3%)	

Table 3: Patients' beliefs about the problem

Subscale	Mean/ SD		F	<i>p</i>	CI	
	'Obese' (n = 184)	'Euphemism' (n = 171)			Upper	Lower
Patient' understanding	3.81 ± 0.89	3.67 ± 1.01	1.73	0.19	0.34	-0.07
Consequences of the problem*	3.51 ± 0.97	3.25 ± 0.99	7.13	0.008	0.49	0.07
Trust in the doctor	3.88 ± 0.88	3.73 ± 1.11	2.70	0.10	0.39	-0.04
Ability to personally control the condition	3.70 ± 0.92	3.66 ± 0.91	0.00	0.98	0.19	-0.19
Timeline	3.21 ± 0.94	3.08 ± 1.06	2.85	0.09	0.39	-0.03
Emotional impact of the problem*	3.75 ± 1.01	3.44 ± 1.11	7.01	0.008	0.52	0.08
Treatment control	3.63 ± 0.81	3.73 ± 0.89	0.53	0.47	0.11	-0.24
Cyclical timeline	3.04 ± 0.86	2.93 ± 0.94	1.49	0.22	0.31	-0.07

*significant effect of condition