



5-2022

Caring for Fat Patients: Bioethical Considerations Surrounding the Duty of Care

Anne Merrill
amerril3@vols.utk.edu

Follow this and additional works at: https://trace.tennessee.edu/utk_gradthes



Part of the [Applied Ethics Commons](#), and the [Ethics and Political Philosophy Commons](#)

Recommended Citation

Merrill, Anne, "Caring for Fat Patients: Bioethical Considerations Surrounding the Duty of Care. " Master's Thesis, University of Tennessee, 2022.
https://trace.tennessee.edu/utk_gradthes/6393

This Thesis is brought to you for free and open access by the Graduate School at TRACE: Tennessee Research and Creative Exchange. It has been accepted for inclusion in Masters Theses by an authorized administrator of TRACE: Tennessee Research and Creative Exchange. For more information, please contact trace@utk.edu.

To the Graduate Council:

I am submitting herewith a thesis written by Anne Merrill entitled "Caring for Fat Patients: Bioethical Considerations Surrounding the Duty of Care." I have examined the final electronic copy of this thesis for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Arts, with a major in Philosophy.

Jonathan Garthoff, Major Professor

We have read this thesis and recommend its acceptance:

Alex Feldt, Mariam Thalos

Accepted for the Council:

Dixie L. Thompson

Vice Provost and Dean of the Graduate School

(Original signatures are on file with official student records.)

**CARING FOR FAT PATIENTS:
BIOETHICAL CONSIDERATIONS
SURROUNDING THE DUTY OF CARE**

A Thesis Presented for the
Master of Arts
Degree
The University of Tennessee, Knoxville

Anne M. Merrill
May 2022

ACKNOWLEDGEMENTS

I want to begin by thanking my committee members Alex Feldt, Jon Garthoff, and Mariam Thalos for their support and patience as I worked on completing my thesis. Thank you all for agreeing to serve on my committee at the last minute and showing interest in my project. I am especially grateful to Alex for his constant encouragement, thoughtful feedback, and frequent philosophical conversations. In every interaction you reminded me why my project mattered and helped make an otherwise stressful process enjoyable.

I am also thankful for my wonderful family for their kind words and willingness to engage with me about my argument. Thanks to my dad, Craig Merrill, for encouraging me to pursue philosophy in the first place and challenging me to examine my beliefs. This project wouldn't have been possible if you hadn't shown me how to be wrong with grace. I also want to thank my mom, Susan Merrill, my brother, Zach Merrill, and my partner, Kelley Foster, for the hours of debate that helped shape my project. Even when your honest feedback went unappreciated in the moment, my project wouldn't have been what it was without your input.

Thank you to my fellow philosophy graduate students for asking thoughtful questions and listening to enthusiastic rants in the grad office. Even though this was my thesis, I never felt alone in the process. A special thanks to Andrew Ertzberger, Ida Mullaart, and Alex Tesar for everything from reading recommendations and thoughtful criticisms to emotional support and constant encouragement. Your assistance in this process has been invaluable.

I am also grateful for the constant support offered by extended family and friends as I worked on this project. I especially want to thank my grandma, Marjorie Matthews, for constantly checking in on me and offering words of encouragement. Thanks also to Gabriella Rezex for being an inspiring role model and amazing friend throughout this process.

Finally, I want to thank Marcus Arvan and Laura Wildemann Kane for fostering an environment where I felt free to explore my philosophical interests and was encouraged to share them with others. In both of your courses I learned how to argue and became comfortable with changing my mind. For all of the experiences I had in your classes, I am forever grateful.

ABSTRACT

Healthcare providers' (HCP) duty of care explains what HCPs owe to all their patients, but this thesis will focus on how the duty of care informs the treatment of fat patients. Currently, the foundation of the duty of care is rooted in a set of principles enumerated by the American Medical Association. This current conception of the duty of care fails to provide basic protections against harm to fat individuals, primarily because it is unable to prevent the negative attitudes HCPs have about fat people from permeating healthcare. The negative attitudes HCPs have about fat patients stem from a societal emphasis on framing fatness as an individual moral failing as opposed to a systemic problem. The social narrative around fatness falsely claims that fat people choose to be fat and that they have a personal responsibility to choose otherwise. This framework causes harm to fat patients through the negative attitudes of HCPs. These harms include a decreased quality of healthcare, damaged relationships between providers and patients, mistrust of diagnoses, and much more. After exploring the harms endured by fat patients and the failure of the current duty of care to protect fat patients from these harms it will be clear that a revised duty of care is needed. The revised duty of care will be constructed from a new set of principles combined with increased educational standards for all providers. The new set of principles will rely on Beauchamp and Childress's Principlism, an account of medical ethics which concentrates on the adoption of four basic principles: respect for autonomy, nonmaleficence, beneficence, and justice (2019). Furthermore, this thesis argues for the need to increase educational requirements for all providers as a means of successfully employing Principlism and guaranteeing fat patients the same protections as others. The revised duty of care will establish a framework that challenges HCPs to ground their attitudes about fat patients in scientific research instead of social narratives and ensure the obligations which stem from the duty of care are applied impartially to all patients.

TABLE OF CONTENTS

Introduction.....	1
Section One Establishing the Duty of Care	3
Fundamental Principles of Medical Ethics	3
Origin and Justification.....	3
Available Principles	4
Establishing the Duty of Care	5
Section Two Failing to Care	7
How Failing to Care Causes Harm	7
Negative Social Attitudes	7
Attitudes about Fatness in Healthcare Settings.....	8
Identifying the Harms	10
Struggling to Breathe	10
Limiting Patient Weight.....	12
The Fifth Principle	13
Conclusion	13
Section Three Upholding Current Duty of Care	14
How the Current Duty of Care Fails to Protect Fat Patients	14
Blood Pressure	14
Type 2 Diabetes	15
Healthy and Fat.....	16
Conclusion	17
Section Four Revising the Duty of Care.....	19
Principles of the Revised Duty of Care.....	19
Respect for Autonomy	20
Nonmaleficence	20
Beneficence.....	21
Justice.....	21
The Revised Duty of Care.....	22
Revised: Limiting Patient Weight.....	23
Revised: Type 2 Diabetes	23
Revised: Struggling to Breathe	24
Requirements of Justice	25
Preventing Negative Social Attitudes	25
Conclusion	26
Section Five The New Duty of Care.....	28
Conclusions.....	28
The Principles	28
List of References	31
Vita.....	34

INTRODUCTION

Fat individuals face bias and stigma in the US despite the prevalence of individuals who either consider themselves fat or would be considered fat according to social standards. Despite the social origins of these negative attitudes about fat people, many describe facing similar attitudes when seeking healthcare. To address how to protect fat patients from health care provider (HCP) bias, this thesis will examine the current infrastructure that guides HCP behavior. The tenants that guide HCP behavior are best captured by the idea of the duty of care. The duty of care is the “general duty to take *reasonable* care to avoid *foreseeable* injury” to others (Bryden & Storey, 2011) and this standard is articulated for HCPs in the American Medical Association’s (AMA) Principles of Medical Ethics¹.

The ultimate goal of this thesis is to outline a new framework for the duty of care, specifically when it comes to interacting with fat patients. However, it is not plainly obvious that there is a need for a new framework for HCPs to follow, so I will spend the majority of the thesis arguing that fat patients are routinely harmed by HCPs even when the current duty of care is fulfilled. In this process I will explain how HCPs harm fat patients when they fail to fulfill the obligations of the duty of care, how they harm fat patients when they satisfy the duty of care requirements, and an explanation for why this occurs and why we ought to take it seriously.

The ethical obligations (and legal standards) create the framework for how HCPs ought to interact with their patients. The goal of the AMA Principles is to establish the standards for interacting with patients in a way that prioritizes HCP responsibility to the patient (*AMA Principles*, 2001). Prioritizing patient care means that HCPs should, in an unbiased manner, “protect the life and health of” and “respect the autonomy of” their patients to a reasonable degree (Doyal, 2001). The foundation of this thesis will rely on an understanding of what is required of HCPs under the duty of care and where those obligations come from. Centering this thesis on a provider’s duty of care will allow for an analysis of HCP attitudes and behavior towards fat patients that examines not only whether providers satisfy the standards of the duty of care, but also whether the current framework is adequately able to protect fat patients from the harmful actions that are a result of the negative attitudes HCPs have about fatness.

Throughout the paper the terms *fat*, *overweight* and *obese* will be used. None of them are being used pejoratively and each term has a specific context in which it will be used. This paper intends *fat* to refer to the non-medical term applicable to all people who fit into the socially constructed category of *fat*. There are no metrics such as BMI, weight, or body fat percentage that a person has to meet for this category to be relevant in their lives; rather all people who have experienced stigma due to their body size may find this categorization relevant to them (Gordon, 2017). The terms *overweight* and *obese* will be

¹ There are different codes of ethics for different medical fields, but the two which are most relevant to this thesis are the AMA Principles of Medical Ethics and the American Nurses Association (ANA) Provisions of the Code of Ethics for Nurses. Both codes are made up of nine nearly identical principles. The AMA (both the organization and the principles) was established in 1847 and the ANA was created in 1896. Since the principles proposed by both organizations are so similar and both are originally derived from historical traditions like the Hippocratic Oath (*World History*, 2009), I will rely on the AMA standards.

used exclusively in reference to the literature and research which uses the terms. In the context of this research, *overweight* and *obese* refer to people with a BMI between 25.0 and 30.0 and a BMI greater than 30.0, respectively. The goal of limiting the use of those terms is to avoid continuing to pathologize fatness. Relatedly, it is important to recognize that the use of the terms *overweight* and *obese* in non-medical settings (and sometimes in medical settings), is both offensive and harmful to fat individuals. This is because both terms imply that not only is a person fat, but that they are *necessarily* unhealthy (Gordon, 2020).

After the principles of medical ethics are outlined, we will examine the current HCP duty of care. The current duty of care is created by the set of AMA Principles and how they are interpreted and applied to caring for fat patients. In the second section, this thesis will discuss how HCPs fail to meet the standards of the current model when it comes to caring for fat patients, focusing on how HCPs harm patients by harboring negative attitudes about fatness. Next, this thesis will address the harms that result for fat patients even when HCPs meet the requirements of the duty of care. This section will be focused on how harms result from the negative attitudes held by HCPs about fat patients that the current duty of care fails to prevent or correct.

To successfully address both how the AMA Principles are violated and the ways in which fat people are harmed even when the Principles are not violated, this thesis will present a survey of the literature surrounding HCP bias against fat patients and the attitudes held about fat patients. We will then analyze cases which capture different kinds of violations of the Principles and the harms felt by fat patients. By looking at accounts of the harm experienced in the context of the duty of care, it will become clear that revisions to the principles are needed.

The final section of this thesis will provide an updated set of principles that prioritize patient health and can be used in establishing a better duty of care. To create the revised duty of care, Beauchamp and Childress's (2019) Principlist account will be analyzed and the importance of education will be outlined. We will revisit some of the cases from the previous sections and explore how a duty of care rooted in Principlism and education is better able to protect fat patients from being harmed by HCPs. This thesis will conclude with a brief argument for why the revised model ought to be accepted over the current model and what a revised set of principles could look like.

SECTION ONE

ESTABLISHING THE DUTY OF CARE

Fundamental Principles of Medical Ethics

The goal of this section of the thesis is to provide a foundation for the moral framework that will help establish what constitutes the duty of care for HCPs. The content of most contemporary accounts of medical ethics can be traced back to the 5th century BCE Hippocratic Corpus (*World History*, 2009). However, the use of the term “medical ethics” didn’t appear in writing until Thomas Percival’s 1803 book *Medical Ethics* (*World History*, 2009). There is a clear connection between both the AMA Principles and the revised principles this thesis will propose and the history of medical ethics. Understanding this foundation is important to explaining not only where the principles come from, but why they ought to be followed. Ultimately, the line of thought that extends from Hippocrates to today in medical ethics guidelines revolves around what it means to be a good doctor. In other words, the duty of care that guides physician behavior and is visible in the moral frameworks discussed in this thesis is rooted in centuries of study of what it means to be a good doctor.

Origin and Justification

The frameworks for the duty of care discussed in this thesis follows from of Hippocrates’ work in the 5th century BCE (*World History*, 2009). When Hippocrates set out to establish professional standards for physicians it was to provide clear criteria to differentiate between legitimate physicians and those who were pretending to be physicians (*World History*, 2009). These professional standards were codified and became The Oath of Hippocrates (Boylan). The Oath of Hippocrates was the primary account of medical ethics until the early 19th century (*World History*, 2009).

Although there were other accounts of medical ethics between Hippocrates and the 19th century, none were as impactful as the work of Thomas Percival. Percival is given credit for being the first person to use the term “medical ethics” in 1803 when his book, *Medical Ethics; Or, A Code of Institutes and Precepts, Adopted to the Professional Conduct of Physicians and Surgeons* was published (*World History*, 2009). Although his book was not internationally successful, it was a foundational text in the US and led the Association of Boston Physicians to create a code of medical ethics in 1808 (*World History*, 2009). The 1808 code would eventually become the model for the AMA’s creation of its own principles (*World History*, 2009).

The first code of medical ethics created by the American Medical Association was published in 1847 and provided a set of professional ethics much like Hippocrates had five centuries earlier. The 1847 code combined the Hippocratic ideals of what it means to be a good doctor (virtues), with the enumerated requirements of Percival (duties), and the binding-ness of the United States Constitution (social contract). These standards were accepted unanimously at the second national convention of American physicians and became a binding document in 1855 (*World History*, 2009). Despite revisions over the past 200 years, many of the initial obligations remain in the most recent version of the

AMA Principles of Medical Ethics, though the document is no longer legally binding (*AMA Principles*, 2001). The current version of the Principles of Medical Ethics, which will be used to assess the practices of health care providers in caring for fat patients, is rooted in historical ethical traditions that recognize the importance of a virtuous character and expect obligations to be taken seriously by health care providers.

The next great shift in the medical ethics sphere came in the mid-to-late 20th century during the Bioethics Revolution. Most notably, in 1974 the United States put together The National Commission for the Protection of Human Subject of Biomedical and Behavioral Research which would later produce the Belmont Report (*World History*, 2009). In 1978 the Commission released the Belmont Report which laid out three basic principles which were to guide any research performed on humans: “respect for persons, beneficence, and justice” (*World History*, 2009). Within a year after the release of the Belmont Report, Tom Beauchamp and James Childress articulated a similar account in the first edition of *Principles of Biomedical Ethics* (*World History*, 2009). Beauchamp and Childress’s principles included respect for autonomy and nonmaleficence to the principles noted in The Belmont Report. The Belmont Report and the *Principles of Biomedical Ethics* created a set of principles which guided action in both medical research and health care that still define both spheres of bioethics today.

Part of the reason why Beauchamp and Childress’s Principlism has remained relevant in medical ethics discourse is because of the way they are applied. The principles proposed by Beauchamp and Childress are rooted in common-morality theory and are continually updated through a process of reflective equilibrium (Beauchamp & Childress, 2019). Beauchamp and Childress’s (2019) conception of reflective equilibrium mirrors John Rawls’s (1971) account and is intended to take the place of both top-down and bottom-up approaches to creating and justifying moral principles. In the context of medical ethics, reflective equilibrium would result in principles that are capable of responding to typical healthcare issues because they are informed by judgements made in light of the healthcare issues.

The other benefit of Beauchamp and Childress’s theory is it’s foundation in common morality. According to Beauchamp and Childress (2019), common-morality theories are pluralistic theories which are rooted in shared moral norms and provide a basis by which to judge ethical theories. Reflective equilibrium and common-morality theory are used in establishing the four principles of bioethics because the resulting principles will be universally applicable and useful in criticizing practices which fall short (Beauchamp & Childress, 2019). Since the principles of autonomy, nonmaleficence, beneficence, and justice are universally applicable and intended to be used as a mechanism through which we can criticize bioethical practices/norms, it is appropriate to use them when judging the current duty of care.

Available Principles

For HCPs today the account that explains what is required to be a good doctor is the AMA Principles. The AMA’s “Principles of Medical Ethics” is made up of a preamble and nine guiding principles (*AMA Principles*, 2001). The preamble specifies that the principles serve to benefit the patient and that “a physician must recognize responsibility

to patients first and foremost, as well as to society, to other health professionals, and to self” (*AMA Principles*, 2001). It concludes by stating that the principles “are not laws, but standards of conduct that define the essentials of honorable behavior for the physician” (*AMA Principles*, 2001). Of the nine principles, the first four focus on responsibilities such as, “providing competent medical care” and “uphold[ing] the standards of professionalism” (*AMA Principles*, 2001). Number five establishes education expectations by requiring providers to “continue to study, apply, and advance scientific knowledge” through a “commitment to medical education” (*AMA Principles*, 2001). Number six grants that in non-emergencies physicians can choose who to care for, number seven establishes a responsibility to engage in public health initiatives, number eight reminds providers to prioritize their patients’ needs, and number nine says physicians should support the right of all people to access health care (*AMA Principles*, 2001). Together, these nine principles establish basic guidance for how HCPs should conduct themselves when caring for patients.

Instead of the explicit principles put forward by the AMA, this thesis argues provider behavior should be guided by the four principles of bioethics outlined by Beauchamp and Childress (Principlism). The principles are: 1) respect for autonomy, 2) nonmaleficence, 3) beneficence, and 4) justice. Beauchamp and Childress (2019) conceived of autonomy as satisfying two basic conditions: liberty and agency. They define liberty as “independence from controlling influences” and agency as “capacity for intentional action.” Respecting autonomy centers on ensuring patients are well-enough informed to create and pursue life plans (Beauchamp & Childress, 2019). The principle of nonmaleficence is explained by the maxim: “one ought not to inflict evil or harm” (Beauchamp & Childress, 2019) Beneficence is represented by three distinct, but related, commitments to prevent harm, remove harm, and promote good (Beauchamp & Childress, 2019). Finally, the principle of justice proposed by Beauchamp and Childress (2019) requires that equals be treated as equals and unequals treated as unequals. What these principles look like in application will be further explored in section four of this thesis.

Establishing the Duty of Care

The current duty of care is rooted in the principles created by the AMA; however, this thesis will argue for a revised duty of care rooted in a different collection of principles. Each set of principles has a different function in establishing and evaluating the duty of care. The Principlist account, for example, offers a more broadly applicable framework and doesn’t assert concrete obligations in the way the AMA standards do. This feature of Principlism can better capture what the duty of care requires in a wider array of interactions. Furthermore, the process of reflective equilibrium allows Principlism to maintain a certain degree of responsiveness that is not apparent in the AMA Principles.

To illustrate this point we can imagine a physician caring for a patient who has poor cognitive abilities such that they would struggle to understand medical diagnoses. If the physician is aware that they have a general obligation to respect this patient’s right to autonomy it would require that the physician give the patient the information they need to pursue life plans. To prevent the patient from overwhelm or unnecessary stress, it could

be permissible to simply tell the patient they are healthy so long as any health conditions do not alter the way one lives their life (ex. mild seasonal allergies, a cold, etc.). The current standard would likely require that the physician tell the patient any trivial health concerns because the principles require honesty “in all professional interactions” (*AMA Principles*, 2001). This could be problematic because requiring honesty *all* the time would reduce, if not eliminate, the doctor’s ability to reduce harm by communicating with a patient in a way that meets the patient’s needs, but may not be the entire truth of the diagnosis. This interpretation is a result of the lack of explanation of what is required to be honest *and* the inability of the current account to allow context-dependent judgments to influence the theory. There are other problems which result from the AMA Principles’ rigidity that we will address throughout the next two sections of this thesis.

That being said, the role for the principles proposed by the AMA would be useful in more standard/less complicated situations. In a scenario with a patient who is fully capable of understanding the complexity of their diagnosis, it is likely best for a physician to disclose all details of a diagnosis and there is likely no need for any discretion to be used. Furthermore, in following the AMA principle regarding honesty in this case, the physician would also satisfy the requirements of the general principle of respect for autonomy. Even though there are cases in which the AMA Principles are effective, this thesis will show that any situations the AMA Principles could be appropriately responsive to, the Principlist account could do the same. However, the inverse is not true. All cases the Principlist account could provide adequate guidance on could not be competently handled by the AMA Principles.

The primary appeal of the AMA Principles is their simplicity. The action (or inaction) required to act in accordance with the AMA standards is easy to understand whereas a Principlist theory could require more thought to apply. If we look back at the example of respect for autonomy vs. honesty, more consideration has to take place to know what course of action is required to respect autonomy, whereas a requirement to be honest in all interactions seems to prescribe a course of action that requires little to no reflection. However, when considering what is required of a duty of care in addressing the needs and interests of fat people, the primary reasons to favor the Principlist approach is that it prevents the negative attitudes of HCPs from causing harm to their patients. This is not something the AMA Principles are able to achieve.

The duty of care is rooted in two different sets of principles: the current duty of care in the AMA Principles and the revised duty of care in Principlism. The rest of this thesis will be spent addressing the effectiveness of each formulation of the duty of care and will demonstrate why there is a need for a revised duty of care and why the revised duty of care should be rooted in the Principlist account.

SECTION TWO

FAILING TO CARE

How Failing to Care Causes Harm

This section will focus on instances where negative attitudes cause HCPs to fail to meet the standards of the AMA principles *and* harm their patient. Understanding of the negative attitudes commonly held by HCPs will be helpful in reasoning about the changes that need to be made to the current duty of care. In this section we will begin by reviewing the typical social attitudes directed at fat people and how those attitudes originated. We will then turn to an examination of the attitudes about fat people that exist within healthcare by looking at research surrounding the attitudes of nurses, doctors, and other healthcare providers about their fat patients. It will be clear that the attitudes held by HCPs mirror the broader social attitudes surrounding fatness. Finally, the connection between HCP attitudes and both the violations of the AMA Principles and the harms caused to fat patients will be shown. The goal of this section is to show that the negative social attitudes surrounding fatness do not only impact fat people in social contexts, but also within medical settings.

Negative Social Attitudes

The historical justification for stigmatizing fat bodies comes from the inferred connection between fatness and the two sins of gluttony and sloth (Pausé, 2017). Gluttony is defined as “an excessive or inordinate craving for the pleasures of eating and drinking” (Backus, 1969). And sloth, which comes from the Greek word *akedia*, is defined in different ways as both “feelings of sorrow and dullness” and “aversion to effort of any kind” (Backus, 1969). The belief that fatness was an indicator of sin eventually gave way to a more modern, secular way to understand fatness as a lack of personal responsibility.

The personal responsibility framing of fatness begins with the idea that fatness is a choice one has full control over; and as such, being fat means that one has *chosen* to be fat. Fatness is a result of the actions, choices, and behaviors of fat individuals (Pausé, 2017). Those who subscribe to this way of thinking believe responsibility for the condition of one’s body rests solely on the individual. Therefore, it is perfectly reasonable to hold fat people accountable for their *choice* to be fat; and implicitly, their *choice* to be unhealthy, diseased, and a burden on the health-care system.

Seemingly, the agreed upon way to ensure fat people are held accountable for their fatness is through stigma. In the context of fatness, stigma serves to describe what it is that makes a person “relevantly different” and “comes to be defined in pejorative terms through dominant cultural beliefs and attitudes” (Nath, 2019). In other words, the stigma that fat people face is a direct result of how society thinks and feels about fatness. This stigma means that fat people are perceived “to be of the lowest social order” (Stoll, 2019) which means they deserve to be stigmatized. The further justify the stigmatization, the perpetrators of the stigma claim they are doing some kind of public service. They’re just trying to help people who *choose* not to help themselves (Anomaly, 2012). Despite the prevalence of fat individuals in society, stigma is regular observed in policies, attitudes, and language. According to Nath (2019), people typically attempt to justifying employing

stigma in one of two ways: (a) public health will be improved if there is less fatness and fatness can be reduced through social sanctions (ex. stigma), or (b) fat people are to blame for their fatness and the stigma they face is a mere consequence of their fatness that was implicitly agreed to when they chose to become fat. The social impacts of the harsh judgments and punishing stigma against fat people can be observed in everything from the size of bathroom stalls, to legal discrimination against hiring fat individuals, to the access fat people have to quality healthcare².

Attitudes about Fatness in Healthcare Settings

When analyzing the data surround negative HCP attitudes and listening to testimony from fat individuals about their own healthcare experiences we can learn about the kinds of interactions that occur between HCPs and patients. Furthermore, when these interactions are considered in the context of general social attitudes about fatness, we can see how social attitudes manifest in provider behavior towards their patients. The result of this connection that will be addressed here is how this causes HCPs to not only harm their patients, but to violate the basic precepts of the current duty of care.

In a metanalysis of nurses' perceptions of fat people, Ian Brown (2006) found four notable attitudes held by nurses: 1) nurses admit to feeling repulsed by overweight patients primarily because they were perceived to be lazy and lacking in self-control, 2) there is a general lack of interest in assisting obese patients with managing their weight (unless patient is suffering from a life-threatening disease), 3) large minorities of nurses agree with stereotypical statements about fat patients as it relates to character traits and likelihood of compliance, and 4) "caring for obese patients is physically exhausting." Brown (2006) also indicates that the most likely reason nurses have negative attitudes surrounding obesity is because of the "negative health consequences of obesity." From this data a clear connection emerges between the personal responsibility framing and HCP attitudes.

Nurses are not the only health care providers who struggle with negative attitudes and beliefs about fat patients. According to Foster, et al. (2003), over half of physicians see obese patients as "awkward, unattractive, ugly, and noncompliant." Similarly, research has found that 45% of physicians sampled admit to having a negative reaction towards obese patients (Sabin et al., 2012). When physicians were questioned about how they perceive of obesity (as a condition rather than a character trait or moral failing) "92% viewed obesity as a chronic condition, only 26% thought anti-obesity agents should be used chronically" (Foster et al., 2003). The disparity between recognizing obesity as a chronic condition and not believing it should be treated is indicative of the personal responsibility perspective. That is, if someone knowingly and intentionally chooses to put themselves in a given situation, then it is solely on them—not the medical practitioner—to remedy the problem. Even though physicians believe obesity is a chronic condition, they appear to view it as a *self-inflicted* chronic condition. A choice.

² Although addressing all the ways in which stigma against fat people manifests is important, the rest of this section will center on how these negative social attitudes show up in healthcare and how that results in harm to fat patients.

The issue with these negative attitudes is not merely that they exist or that they're rooted in social norms instead of science; rather it's that they fundamentally influence how providers interact with their patients. To highlight disparities in accessing quality care, the experiences of fat patients can be compared to the experiences of non-fat patients. There are four main disparities observed between the kind of care received by obese³ and non-obese people: 1) less patient-centered communication occurs between providers and obese patients, 2) there is generally less respect shown for obese patients, 3) on average providers spend less time in the room with obese patients compared to non-obese patients, and 4) it is significantly more likely that an HCP will claim weight is the primary cause of illness (even if there is not a clear relation between presenting problem and body weight) (Phelan et al., 2015). Phelan et al. (2015) claims that these disparities suffered by obese people are similar to the disparities faced by oppressed racial groups and that both fat patients and oppressed racial groups can trace the disparity in the care received back to the negative provider attitudes.

In addition to the direct negative impacts of HCP attitudes, there are less obvious, but arguably just as problematic, impacts that occur in a more indirect manner. For example, when fat patients perceive the negative attitudes of their provider, "these patients will feel that nurses are not supportive, and they may, therefore, feel reluctant to access services" (Brown, 2006). Similarly, if the obese patient is aware of the provider's negative attitude the communication between the two is worsened and this poor communication is directly related to the reduced likelihood that the obese patient will comply with medical advice (Phelan et al., 2015). Regardless of whether the harm faced by fat patients is of a direct or indirect manner, both ought to be addressed with urgency so that fat patients can access quality healthcare and the influence of social stigma in medicine can be reduced.

The similarities between the negative attitudes of HCPs and those of society in general regarding fat people are demonstrative of the way in which social attitudes influence medical practitioners. Intuitively, this ought not be surprising as we know that providers are also members of the broader social community and are likely to carry judgments and biases from the social sphere into their positions in healthcare. This intuition is easily confirmed by examining the results of implicit association studies performed on providers and the general public. According to Sabin et al. (2012), "the results for MDs are similar to results from large samples of the general public who voluntarily take the Weight Implicit Association Test on the Project Implicit web site." The results of the tests taken by doctors and the results of those in the general public tend to follow "the same general pattern" which is indicative of the influence that social stigma and attitudes have on HCPs (Sabin et al., 2012). They also note that the observation of strong explicit attitudes in both doctors and individuals "suggest that [they] may feel that it is socially acceptable to express negative attitudes about overweight people" (Sabin et al., 2012). By openly expressing their attitudes about fat patients, HCPs perpetuate the harmful impacts that negative attitudes can have on fat individuals.

³ There are no indications that this kind of care is received exclusively by obese people.

Identifying the Harms

In this section we will discuss five specific harms caused to fat patients by the attitudes of HCPs. According to Meredith Bessey and Daphne Lordly (2020), these five potential harms are the result of negative attitudes producing the assumption that being fat is indicative of poor health, which means that treating obesity is a good thing to do because being fat poses a greater risk to a person than does the risk of treating obesity.

The first of the five possible harms that could result is that fat patients display a reluctance to seek health care because they would rather endure “minor” illness than endure an interaction with their health care provider (Bessey & Lordly, 2020; Gordon, 2020). Avoiding seeking medical care when it is needed can lead to delayed diagnosis, reduced quality of life, and increased stress/anxiety about health (Gordon, 2020). The second of the resulting harms is compromised patient care (Bessey & Lordly, 2020). Poor communication between providers and patients leads to a decreased likelihood of patient compliance and future reluctance to seek out medical care (Phelan et al., 2015). Avoiding medical care and failing to comply with medical advice can pose life threatening risks to patients and both behaviors can be connected to HCP attitudes.

The general idea described in the third, fourth, and fifth harms is that fat patients are likely to internalize any felt stigma which leads to blaming themselves for their bodies (Bessey & Lordly, 2020; Gordon, 2020). This internalized stigma also results in fat people being likely to experience feelings of social isolation, especially if they are experiencing health problems for which they are reluctant to seek medical advice (Bessey & Lordly, 2020). When combined, these two things lead to increased rates of anxiety and depression, poor body image, and low self-esteem (Bessey & Lordly, 2020; Gordon, 2020). Even if HCP attitudes are not directly responsible for poor mental health conditions, the connection between negative attitudes and stigma to poor mental health is well established through data and the cataloged experiences of fat patients.

We will now examine the harms that occur simultaneously with HCPs violating the current duty of care. To accomplish this, several cases will be presented and the violations of the AMA Principles will be highlighted. The goal of analyzing these cases is to show that it is possible for negative HCP attitudes to lead to violations of the AMA principles and harm fat patients.

Struggling to Breathe

In 2016 *The New York Times* published a story about Jane⁴, a 46-year-old woman who developed a sudden difficulty breathing. She found herself suddenly unable to walk between rooms in her house without feeling extremely short of breath. Concerned about the sudden development she sought help from a local urgent care. The provider listened to Jane’s case and told her that “the only thing wrong with her...was that she was fat” (Kolata, 2016). When the woman pushed back, the doctor told her that obesity can cause a sudden onset of breathing issues and asked if she has ever thought about dieting (Kolata, 2016). When Jane visited another provider, one who took her concerns seriously, it was discovered that she had numerous, potentially deadly blood clots in her lungs that

⁴ Not her actual name. The woman in *The New York Times* story chose to remain unnamed.

were causing the breathing difficulties (Kolata, 2016). The provider in Jane’s case was in violation of three of the AMA Principles.

The first principle in the AMA’s “Principles of Medical Ethics” requires care that shows “compassion and respect for human dignity and rights” (*AMA Principles*, 2001). Although the requirements of “compassion” and “respect” are not specifically defined by the AMA, if a physician has an attitude which leads to being rude and dismissive during a patient encounter, that would be considered a failure to recognize the patient’s dignity (Jacobsen, 2009). These behaviors by a HCP would also be indicative of a lack of compassion for the patient and their concerns. When considering Jane’s case, it is clear that the provider violated the first principle when they dismissed her concerns as merely a fat problem and condescendingly gave her the advice to “try dieting.”

Principle number three requires physicians to follow the law and says they have “a responsibility to seek changes in those requirements which are contrary to the best interests of the patient” (*AMA Principles*, 2001). Although there are non-medical laws that disadvantage fat people, for example discrimination against fat people is legal in every state except Michigan and a few cities across the US (Eidelson, 2022); there are not any specific medical laws which categorically disadvantage fat patients. However, there is more that HCPs could do to create policies and guidelines (that may not be legally binding) which would advance the interests of fat patients⁵. In the context of Jane’s case, the urgent care physician failed to perform routine tests (ex. a chest x-ray or CT scan of her lungs) which meant the blood clots were not identified. If there were requirements in place that mandated certain procedures or exams for certain patient complaints, then it could be more difficult for HCPs to provide fat patients with worse care. And, perhaps, Jane could have been treated sooner.

Related to principle three is the ninth principle of medical ethics which requires physicians to support healthcare access for all people (*AMA Principles*, 2001). Given that the formulation of this principle is in a positive sense (it requires physicians to support access to healthcare as opposed to simply not preventing people from having access to health care), it is reasonable to expect physicians to treat each patient they encounter as if that individual has a right to healthcare access. However, this demonstrates another shortcoming of the AMA’s Principles: failing to specify that HCPs ought to support access to *quality* care, not just any kind of care. In Jane’s case the ninth principle would be violated either way as the “care” she received at urgent care was effectively no different from a scenario in which Jane had no healthcare access at all. The dismissal of the seriousness of Jane’s complaint effectively denied her the access to healthcare that physicians ought to support.

Lastly, principle eight says, when treating a patient, a physician should “regard responsibility to the patient as paramount” (*AMA Principles*, 2001). This principle basically functions as an agreement from the physician that once they decide to treat a

⁵ The vagueness of the principles proposed by the AMA again becomes an issue here. The principle the AMA put forward doesn’t limit advocacy requirements to *only* medical requirements, so it is not clear that the scope of the principle should be limited to medicine. To that point, we can also link poverty (resulting from unemployment) to increased weight and various health issues, so there is good reason to think that HCP requirements under this principle extend beyond the boundaries of healthcare.

given patient, they will prioritize providing quality care to that patient. In Jane's case, the violation of this principle is perhaps the most obvious violation. The urgent care physician agreed to treat Jane, but then did not take her concerns seriously or provide the kind of testing/care that Jane was deserving of.

Limiting Patient Weight

In 2012 Dr. Helen Carter, an internal medicine physician, cited injury to a staff member and the cost of new exam tables as the justification for her practice's new policy: no patients over 200 pounds (Zimmerman, 2012). Carter claimed that she doesn't treat individuals struggling with addiction because addiction is not her specialty and that her latest policy was just a different version of the same principle, "obese patients in the region would be better served at a facility like the weight loss center at UMass Memorial" (Zimmerman, 2012).

Despite the attempt at making the policy seem like she was just being a responsible practitioner, there are two main problems with the justification provided. The first being that just because a person is considered obese, does not mean that the medical care required is weight intervention. Obese people, like non-obese people, are capable of suffering from all kinds of non-weight related conditions that an internist could treat. The second problem is that staff safety and cost of equipment is not a burden that ought to be placed on the patient. Just as HCPs may be required to employ new training or techniques to care for patients who have difficulties hearing, seeing, or comprehending the medical advice they are given, HCPs may be required to learn how to safely maneuver fat patients to protect staff and equipment.

The sixth principle, like the third and ninth principle, addresses access to care. Principle six states that outside of emergencies, physicians can choose which individuals they will provide care. The freedom given to HCPs to reject patients without explanation is the policy which, in theory, would only be used to allow physicians to deny care to people on morally objectionable grounds (ex. Catholic physicians and hospitals are not required to perform abortions). However, in practice, this policy leaves room for flagrant discrimination against fat people (and other unprotected populations).

Dr. Carter was also likely violating principle two when she categorically denied people over 200 pounds from being treated at her practice. The second principle requires providers to be professional, honest, and "strive to report physicians deficient in character or competence" (*AMA Principles*, 2001). Although the policy instituted by Dr. Carter was perfectly legal, it did signal that she was "deficient in character" because the kind of discrimination that occurred was harmful and shows little regard for the welfare of others. However, it is important to note that the second principle does not explicitly state that being of good character is required for upholding the standards of professionalism, nor does it state that physicians are responsible for their own deficient character. Again, the vague nature of the principle undermines its potential efficacy. Despite this lack of specificity, it would seem necessary that providers must be expected to not be deficient in character if they are required to report others who are.

The Fifth Principle

The principle which stands the best chance of protecting fat patients is principle number five: physicians should “continue to study, apply, and advance scientific knowledge,” and “maintain a commitment to medical education” (*AMA Principles*, 2001). The requirements of this principle will be addressed in detail in section four as the key to preventing negative social attitudes from interfering with patient care. If HCPs were more dedicated to staying up to date with medical and scientific knowledge surrounding fatness, it is likely that some of the obstacles faced by fat individuals in accessing quality health care would be eliminated.

For example, if Dr. Carter was educated about fatness, she would recognize that fat patients are capable of experiencing non-weight related conditions and therefore would not need to visit a weight loss clinic for all health concerns. To that point, if Dr. Carter was aware of uncontrollable factors (ex. genetics, the environment, etc.) which influence how much fat a person has on their body, then she would (hopefully) recognize that her policy would be discriminating on unfair grounds.

In Jane’s case education could play a similar role. If the urgent care provider was aware of the connections (and lack of connections) between the amount of fat on one’s body and their health, it is less likely Jane’s HCP would have automatically assumed her sudden breathing difficulties were at all related to being fat. As Gordon (2020) notes, there is an assumption that fat equals diseased, unhealthy, and constantly nearing death. Education could play a crucial role in undermining the current perspective on fatness and could prevent cases like Jane’s from being commonplace.

Conclusion

The remaining two principles presented by the AMA are less relevant to the specific content of this thesis as they deal with physician conduct that occurs outside the scope of caring for fat patients. Principle seven is addressing public health measures and the role of providers in community health initiatives. Principle four is speaking to patients’ privacy rights as it relates to their medical information. In the final section of the thesis when the revised duty of care is laid out, we will analyze these two principles in the context of Principlism to identify whether or not they ought to remain in the revised set of principles.

In this section the various ethical principles which providers violate in caring for fat patients was explored along with how patients are harmed by those violations. The reasonable conclusion to draw from this section would be to suggest that perhaps the harms experienced by patients are a direct result of the violations of the AMA Principles and that, so long as HCPs don’t violate the AMA Principles, their patients will not be harmed. However, I will argue that this is not a sufficient solution to the problems faced by fat patients in healthcare settings. The next section of the thesis will explore cases in which HCPs have plausible deniability against accusations that they violated the AMA Principles, and yet the harm caused to patients is undeniable.

SECTION THREE

UPHOLDING CURRENT DUTY OF CARE

How the Current Duty of Care Fails to Protect Fat Patients

Similar harms to the variety discussed in section two can occur even when HCPs adhere to the guidelines. The goal of this section is to examine how it is possible that HCPs can adhere to the AMA guidelines in place for them and cause harm to their patients. We will examine a new set of cases in this section to understand how it is possible for HCPs to harm their patients while adhering to the AMA standards. These cases will also demonstrate the ineffectiveness of the AMA Principles in protecting fat patients from harm. This is important because in the previous section the AMA principles were violated so it was not clear whether the harms came from the violation of the AMA principles or from the negative attitudes themselves. Through showing that patients can still be harmed even when the AMA Principles are not violated, it will become clear that the source of the harms does not have to be linked directly to violations of the moral principles, but can be connected instead to the negative attitudes of healthcare providers.

The result of this argument will show that even when HCPs adhere to the AMA principles, fat patients are uniquely exposed to harms which stem from an inadequate conception of the duty of care. The three cases discussed in this section are not intended to be a complete list of the ways in which HCPs can cause harm while adhering to the AMA Principles; rather they function to show that the harms experienced by fat patients are present in a variety of cases.

Blood Pressure

On a trip to visit her family Aubrey Gordon (2020) partially lost her hearing and sought care at a California urgent care center. The nurse came in to take Gordon's vitals and paused after Gordon's blood pressure reading (Gordon, 2020). The nurse then left the room and came back with a larger blood pressure cuff. After seeing the nurse's persistent puzzled expression Gordon asked what was wrong (Gordon, 2020). The nurse replied that her blood pressure cuff must be broken because Gordon's blood pressure was great, but "obese patients don't have good blood pressure" (Gordon, 2020).

The experienced harm in this situation came from the fact that the nurse thought "being fat meant being sick," (Gordon, 2020) and that her negative beliefs about fat people caused her to default to her assumptions instead of trusting the health data that was right in front of her. Gordon writes, "my sickness was inevitable, so good health was unfathomable" (Gordon, 2020). In this experience, the harm is clear, for a trusted HCP to assume that a patient's fatness meant the patient could not be healthy is harmful to the patient as it can damage their self-perception and perhaps harm the relationship between the HCP and the patient.

However, that the HCP causes harm to the patient does not require that the HCP violates the AMA Principles. As I argued in the previous section, it is of course possible for a HCP to violate the current principles and cause harm to the patient, but in this case the nurse could reasonably argue that no ethical violations occurred. The nurse could argue that based on her experiences with fat patients, it is uncommon to see blood

pressure fall within a certain range. So, when the nurse acted in accordance with how her experience told her to act, she was coming from a place of concern. Furthermore, she was acting in the best interests of her patient, as would be required to respect Gordon's dignity, by seeking out accurate information for her patient. From the nurse's perspective it could be the case that she believes her actions would be comparable to seeking a new thermometer if a patient, who by all other signs did not have a fever, was producing a temperature over 100 degrees.

All of this is not to say definitively that the nurse did *not* violate the AMA Principles, it is just to show that there is reasonable account of the nurse's actions that can provide a plausible explanation for how she did not violate the principles. Regardless of whether the nurse *for sure* violated the AMA Principles, the patient, Gordon, was harmed by the nurse's actions

Type 2 Diabetes

At Rashelle Hamilton's first postpartum physical in December 2020 her doctor diagnosed her with T2DM (Type 2 Diabetes Mellitus) and put her on an \$800 per week injection to manage her condition (Engel-Smith, 2021). The problem, though, is that her doctor announced her diagnosis and began her injections prior to getting results of her blood work (Engel-Smith, 2021). When Hamilton's blood work came back she learned that she did not have T2DM and therefore did not need to be on any medication for the condition (Engel-Smith, 2021).

In this case the harm occurred in four different ways: on a practical level, the expense of the medication and the harm to Hamilton's body from taking insulin when it was not needed. Third, Hamilton lost trust in her doctor and had to find a new provider after the experience (Engel-Smith, 2021). The fourth harm is a result of the doctor's assumption that Hamilton's fatness is indicative of her overall health. The doctor's negative attitude resulted in a harmful assumption that the doctor felt confident enough in to begin treating the condition. The harm in this case can be understood by reflecting on the research of Bessey and Lordly (2020) from section two. The unnecessary diabetes treatment can function as evidence for Hamilton that her provider holds negative beliefs about her because of her size. Hamilton being aware of this can lead to internalized shame and mental health concerns (Bessey & Lordly, 2020).

Despite the harms Hamilton endured because of her HCP's attitudes and assumptions, it is plausible that the HCP did not violate any of the current AMA principles. Given the seriousness of T2DM and the havoc it can wreak on the body, Hamilton's HCP could argue that beginning treatment as soon as possible was of critical importance to preserving patient health. Consider a more common practice that is not typically seen as harmful: starting a patient on antibiotics prior to knowing *for sure* that the patient had an infection. For example, after experiencing a dog bite that breaks the skin providers will typically prescribe antibiotics as a precaution. A similar procedure occurs for children with strep throat. The test is sent to the lab to establish the diagnosis, but in the meantime the child is started on antibiotics.

By acting with urgency and beginning treatment right away, Hamilton's provider could argue they were adhering to the AMA principles by prioritizing the patient's health

and showing compassion for the patient by trying to reduce their symptoms as soon as possible. The likely objection to these analogies would address how much more dangerous it is to take insulin when one does not have T2DM as compared with taking antibiotics if there is no infection present. However, it would not be unreasonable for the provider to claim that T2DM is also a much more threatening condition than most infections, so the provider believed it was urgent that treatment begin. The mechanism which causes the harm in this case is much the same as in the last case: the judgment about whether a patient has been exposed to bacteria from the dog's mouth or strep throat is rooted in science. However, the basis on which the patient was diagnosed with T2DM stems from negative attitudes and harmful assumptions about the inability of a fat person to be healthy. In the calculation between money (\$800 a week) and Hamilton's health, the HCP chose to try to protect Hamilton's life. It is not unreasonable to defend her HCP's actions in this way.

Healthy and Fat

My friend Kate⁶ has been fat for as long as she can remember. Her doctors have also taken issue with her size for as long as she can remember. As a kid she was athletic, a good student, and showed no signs of a poor relationship with food. Kate's adult life doesn't look much different. However, every time Kate goes to the doctor for her annual physical her doctor concludes the appointment by telling Kate she seems to be in good health, but follows that up by asking Kate if she has ever considered dieting. At that point Kate's confusion sets in because if all metrics⁷ indicate health, why would she have to consider dieting?

Kate's case presents a unique circumstance as there are two kinds of harms which stem from her doctor's advice: realized harms and potential harms. Realized harms are those which occurred at the time of the incident or shortly thereafter. In Kate's case, the realized harms would be similar to those faced by Gordon and Hamilton in the previous two cases. She is harmed as a direct result of her provider's assumption that health and fatness cannot exist simultaneously in the same body. Her awareness of this assumption will likely follow the same pattern described by Bessey and Lordly (2020): the internalized stigma from her doctor will have adverse impacts on her relationship with him, her self-perception, and increase the risk of developing mental health conditions.

The potential harms that result in Kate's situation stem from the negative impacts that dieting can have on a person. Non-surgical interventions for weight loss, especially in obese patients, are rarely successful (Fildes et al., 2015) and can have harmful impacts on a patient's mental health (Gordon, 2020). Furthermore, the latest research indicates that obesity alone is not to blame for poor health (Kennedy et al., 2018), so a recommendation to diet on the basis that Kate's weight is making her unhealthy is illogical.

⁶ Her name has been changed for privacy.

⁷ Perhaps Kate's BMI, body fat percentage, or overall weight are too high, but it's not clear in the literature whether those things are relevant indicators of actual health. Studies have found that the more reliable indicators of health are things like physical fitness, smoking, alcohol consumption, and consumption of fruits and vegetables among other things (Loef & Walach, 2012; Fogelholm, M.).

Of the three cases addressed in this section, the action of Kate's HCP has the weakest defense of his actions. This is caused by the incompleteness of any information used in justifying his behavior. For example, it is commonly argued that one of the reasons fat people ought to lose weight is because if they don't they will die earlier than their thin counterparts⁸ (Gorman, 2016). Her HCP could also justify his behavior by appealing to the idea of prevention: advising weight loss is a way to show concern for the patient because it is in the patient's best interest to avoid becoming diabetic. There is no denying a strong connection between weight and T2DM (Powell, 2012), but the picture is more complicated than the oversimplified rhetoric indicates⁹ (Malone & Hansen, 2019; Pantalone et al., 2017).

The weakness of these defenses is caused by the incomplete knowledge of Kate's HCP (which would be a violation of principle number five of the AMA Principles). However, the principle is not well defined by the AMA. The current principle does not establish the standard of continued education required of providers which makes it difficult to decide whether the actions of Kate's HCP violate the principle. Excluding the fifth principle due to its lack of clarity, Kate's HCP could argue with relative ease that his actions showed compassion, respect for Kate's dignity, and appropriately prioritized her interests.

Conclusion

The influence of negative attitudes on HCPs is also observed in HCP behavior when the AMA Principles are not violated. The harm that results from HCP action is rooted in HCP attitudes about fatness. As was noted in the cases, the idea that a fat person cannot be healthy and therefore must be ill or show signs of impending illness is a direct result of social rhetoric influencing HCP behavior (Gordon, 2020). As we have seen, it is possible for HCPs to argue that their actions fall within the scope of what is permissible under the AMA Principles while still causing harm to their patients. The aim of this section was to show that not all cases of harm entail violations of the AMA principles that providers are supposed to follow.

The goal of this thesis is to establish ethical guidelines for HCPs that provide a foundation for the duty of care, and it is clear that the AMA Principles do not provide this foundation. If the current principles did provide adequate protection, then there would be few to no harms caused by HCPs when no principle was violated. If the ethical standards

⁸ A 2016 study published in *JAMA The Journal of the American Medical Association* detailed findings out of Denmark that showed "the BMI associated with the lowest risk of dying from any cause...was 23.7 in the 1970s, 24.6 in the 1990s and 27.0 in the present" (Gorman, 2016). Although this specific study was confined to Denmark, researchers from the University of Alabama at Birmingham, the National Institute on Aging in the US, and the National Center for Health Statistics have showed similar findings on both national and international levels (Gorman, 2016).

⁹ Research done at Harvard University within the last decade establishes the tight connection between fatness and diabetes. Their research showed that those who are overweight are five times more likely to develop T2DM and those who are obese are 60 times more likely to develop T2DM (Powell, 2012). That being said, research from 2018 concludes that obesity is connected to developing T2DM, but that those who are genetically predisposed to developing T2DM are at an increased risk of becoming obese (Malone & Hansen, 2018). Relatedly, the research out of Harvard noted that insulin itself is known to cause weight gain (Powell, 2012).

provided adequate protection, then anytime the principles were upheld the patient would be free from harm.

SECTION FOUR

REVISING THE DUTY OF CARE

Principles of the Revised Duty of Care

In this section we will review a revised account of the duty of care with a foundation rooted in Beauchamp and Childress's *Principles of Medical Ethics* (2019) instead of the AMA Principles. The goal of the revised duty of care is to account for the unique interests and needs of fat patients, while ensuring it is still broadly applicable to all who seek medical care. The primary difference between the duty of care which stems from the AMA Principles and the revised duty of care is that the former offers more narrowly applicable guidance compared with the latter. The impact of this is that the revised duty of care may not be laid out in nine neat principles, but its ability to guide HCPs in providing adequate care for their patients will be far greater.

The development of the revised account begins with the four main principles which create the foundation for the revised duty of care: respect for autonomy, nonmaleficence, beneficence, and justice. This outline will explain how Beauchamp and Childress conceive of the principles and will make clear the role each one plays in creating the ethical guidelines for HCPs in caring for fat patients. After the principles have been laid out we will explore some of the previous considerations of this thesis in the context of Principlism. Among the considerations included is a comparison of both accounts (the AMA and Principlism), whether the revised duty of care better protects fat patients, and the role that continued education can have as a mechanism for preventing harm to fat patients.

As stated by Beauchamp and Childress, the goal of their project is to create an account that will contribute to biomedical ethics in an original way. The gap they intend to fill in biomedical ethics discourse appears to be the one created by reliance on accounts built from "general principles" and "paradigm cases" (Beauchamp & Childress, 2019). To accomplish this, they imagine the four principles being the "backbone" of the project and then ensuring the obligations based on the four principles are successfully protecting the rights, interests, and welfare of those impacted in a non-biased and coherent manner (Beauchamp & Childress, 2019).

The four principles discussed were chosen because they fit within the theory of common morality¹⁰, "the set of universal norms shared by all persons committed to morality" (Beauchamp & Childress, 2019). The benefit of starting from common morality is that, "it is applicable to all persons in all places and we appropriately judge all human conduct by its standards" (Beauchamp & Childress, 2019). The implication of this is that all HCPs can be judged impartially in accordance with the revised duty of care. This means that as long as the revised duty of care is capable of protecting fat patients, they will be protected when seeking care from any provider.

¹⁰ A more detailed discussion which explains the justification for the use of common morality theory can be found in section one.

Respect for Autonomy

Beauchamp and Childress's account of biomedical ethics begins with the principle of respect for autonomy. Their account of autonomy addressed the role of autonomous choice and outlines what is required to enable patients to make autonomous life choices (Beauchamp & Childress, 2019). There are three conditions that comprise the principle of respect for autonomy: (1) intentionality, (2) understanding, and (3) non-control (Beauchamp & Childress, 2019). Intentionality is a person's ability to create plans and pursue them; understanding requires a "substantial degree of understanding," but does not require complete understanding, and non-control means that there are no external or internal factors removing an individual's self-governance (Beauchamp & Childress, 2019).

In addition to the three conditions just mentioned, there are other positive and negative duties involved in respecting autonomy. To respect the autonomy of another requires "[acknowledging their right to hold views, to make choices, and to take actions based on their values and beliefs. Respect is shown through respectful *action*, not merely by a respectful *attitude*" (Beauchamp & Childress, 2019). So, to respect the autonomy of others means not only ensuring the individual has the conditions to *potentially* act autonomously, but to recognize and allow a person to realize that potential. Disrespecting autonomy is to "ignore, insult, demean, or [be] inattentive to others' rights of autonomous action" (Beauchamp & Childress, 2019). To respect a person's autonomy may require HCPs to not only avoid controlling their patients' actions, but to share any information their patient may need to understand the relevant factors which impact plans of action.

Nonmaleficence

The principle of nonmaleficence is a fairly strict requirement on HCPs (and non-HCPs) to "not inflict evil or harm" on others (Beauchamp & Childress, 2019). According to Beauchamp and Childress (2019), the "rules of nonmaleficence (1) are negative prohibitions of action, (2) must be followed impartially, and (3) provide moral reasons for legal prohibitions of certain forms of conduct." Related to the rules of nonmaleficence, Beauchamp and Childress argue that it is possible for an HCP to harm someone (or place someone at risk of being harmed) without malicious or harmful intent, but the HCP could still be morally responsible for the resulting harms. In other words, an HCP can still be responsible for the harm, even if it was unintended (Beauchamp & Childress, 2019).

In the context of the principle of nonmaleficence, harm is defined as "a thwarting, defeating or setting back of some party's interests" (Beauchamp & Childress, 2019). This conception of harm appeals to the idea of common morality in that even those who see harm as a "contested concept" are still likely to agree that physical harms or severely impacted life plans are harms (Beauchamp & Childress, 2019). They do not differentiate between "trivial harms" and "serious harms" since, in practice, their conception of harm only includes the latter (Beauchamp & Childress, 2019).

The last component of the principle of nonmaleficence is the idea of negligence. Beauchamp and Childress (2019) differentiate between two different kinds of negligence: those which "intentionally [impose] unreasonable risks of harm" and those which

“unintentionally but carelessly [impose] risks of harm.” Both kinds of negligence are relevant to the present discussion of the experiences of fat patients in medical settings.

Beneficence

The principles of nonmaleficence and beneficence are typically discussed together, but Beauchamp and Childress outline the important differences between the two principles as they relate to a theory of bioethics. The rules of beneficence “(1) present positive requirements of action, (2) need not always be followed impartially, and (3) generally do not provide reasons for legal punishment when agents fail to abide them” (Beauchamp & Childress, 2019). As it pertains to the second rule of beneficence, Beauchamp and Childress (2019) note that there are instances in which we are required to impartially apply the principle of beneficence. To better distinguish between cases in which one must act impartially from those in which it is permissible to act with partiality, they differentiate between general and specific beneficence.

Obligations of general beneficence is typically the idea at play in conversations about altruism, improving the lives of strangers, etc. and whether general obligations of beneficence exist is less clear (Beauchamp & Childress, 2019). The obligations which stem from specific beneficence are the kind this thesis will be concerned with. The obligations which come from specific beneficence are impartial in the sense that they usually stem from commitments made or implied between parties. For example, “many specific obligations of beneficence in health care...rest on a health professional’s assumption of obligations through entering a profession and taking on professional roles” (Beauchamp & Childress, 2019). The duty that HCPs have to their patients stems from the fact that they chose and agreed to be a health care worker.

The last feature of beneficence that needs to be addressed surrounds the idea that sometimes to act beneficently can mean acting paternalistically. In terms of the principles put forward by Beauchamp and Childress, paternalism would be instances in which conflict occurs between the principle of beneficence and the principle of respect for autonomy. In the context of caring for fat patients, concerns about paternalism stem from the personal responsibility framing of fatness. For example, if a person *chose* to be fat and will not choose to be otherwise, then the HCP has no other option but to prioritize beneficence (insisting the patient lose weight for their own good) over respect for autonomy. The relevance of paternalism will be addressed again when analyzing how the revised duty of care can better serve fat patients.

Justice

Beauchamp and Childress use a “formal principle of justice” to begin their analysis of how justice relates to bioethics. The formal principle employed is, “equals must be treated equally, and unequals must be treated unequally,” and then to understand what exactly is meant by the formal principle they turn to “material principles of justice” (Beauchamp & Childress, 2019). The material principles of justice are intended to identify the relevant characteristics on which equal treatment should be based. They claim that, “material principles identify morally relevant properties that persons must possess to qualify for particular distributions,” and that the relevance of the properties is

debated in differing theoretical and practical settings (Beauchamp & Childress, 2019). The implication of this is that to have a principle of justice means there must be a way to analyze which properties are relevant and which are not; and to make this analysis, a theory to select the relevant material principles of distributive justice is needed (Beauchamp & Childress, 2019).

In articulating their principle of justice Beauchamp and Childress consider six different theories of material principles of distributive justice: utilitarianism, libertarianism, communitarianism, egalitarianism, capability theory, and well-being theory (Beauchamp & Childress, 2019). Although Beauchamp and Childress spend ample time developing a principle of justice that considers a wide variety of biomedical considerations, for the purposes of this project it is not necessary to explore the entirety of their account. What Beauchamp and Childress focus on is the idea of fairness: that people should not receive or be denied benefits because of undeserved advantages or disadvantages they may face (Beauchamp & Childress, 2019). In the context of the present discussion, the principle of justice would require that fat patients not be denied access to the same quality healthcare received by non-fat individuals.

The Revised Duty of Care

Using the work of Beauchamp and Childress as the foundation, the revised duty of care is better able to account for patients of all kinds in healthcare settings. The following discussion is not intended to be an exhaustive list of the ways in which the revised duty of care is an improvement from the AMA Principles, but is intended to give sufficient proof to justify the project.

The AMA Principles discuss HCP obligations to respect the dignity of patients and to act in their best interests¹¹ however there is no explanation of what is required in order to satisfy those requirements. The danger of not having these obligations defined was shown in the cases where HCPs may not have violated the AMA standards, but still caused harm to their patients¹². In the revised duty of care the commitments of HCPs is more clear. To respect the dignity of a patient means (1) respect their ability to make choices and life plans for themselves, (2) avoid harming the patient by acting negligently, (3) actively support and encourage patients in pursuit of their life plans, and (4) ensure the varying interests and needs of patients are shown equal respect. In this instance, multiple principles from Beauchamp and Childress were able to replace the vague requirements put forward by the AMA.

In other cases, individual principles from the revised duty of care can be put in place to capture the sentiment/obligation proposed by the AMA. For example, principle number nine from the AMA states, “a physician shall support access to medical care for all people” (*AMA Principles*, 2001). This idea can be replaced by the principle of justice proposed by Beauchamp and Childress and would result in a principle which told us what is required from HCPs to *support* access to medical care for all people, what level of medical care ought to be provided, how to assess which people get what services, and

¹¹ See Principles 1, 3, 7, and 8.

¹² See section three for the complete discussion.

more. The revised duty of care is able to provide a detailed, action-guiding framework for thinking about how to care for patients.

The care which would be received under the revised duty of care will be discussed in the context of some of the cases discussed previously. In each case, the obligations which stem from the principles of respect for autonomy, nonmaleficence, and beneficence are case-specific. However, the obligations which stem from the principle of justice does not vary much in its application to each case. For that reason I will discuss the requirements of the principles of respect for autonomy, nonmaleficence, and beneficence in context of each case and then conclude with an explanation of how the obligations which stem from the principle of justice applies to each case.

Revised: Limiting Patient Weight

The first case to consider is that of Dr. Helen Carter¹³ who implemented a policy that she would not treat any patients over 200 lbs. Dr. Carter is a prime example of someone acting paternalistically when it comes to the interests of fat patients. She claims that by not seeing patients over 200 pounds it will encourage people to lose weight (Zimmerman, 2012). In other words, since fat people could choose to be otherwise, she has a responsibility to encourage them to make that decision for their own good instead of respecting their choice to be fat. The central problem with that line of reasoning is that fat people cannot just *choose* to be otherwise as there are genetic and environmental factors which are uncontrollable. Furthermore, her paternalistic attitude comes from a place of stigmatizing fat people, which would certainly violate the principle of beneficence.

A further violation of the principle of beneficence occurs in the implications of Dr. Carter's actions. Because she is a HCP she has specific obligations of beneficence to provide care for people. By discriminating against potential patients on such trivial grounds, Dr. Carter could be establishing moral precedent which would allow continued discrimination on all kinds of trivial grounds (i.e. race, sex, gender, etc.). In applying her specific obligations of beneficence in a partial way when they ought to be applied impartially, Dr. Carter is violating the responsibilities which stem from the principle of beneficence and laying groundwork for future discrimination.

Lastly, Dr. Carter would be in violation of the principle of nonmaleficence because denying a person care could put them in a position where they are at risk of unreasonable harms. It could certainly be argued that there are other HCPs that patients over 200 pounds could see to receive care, but that objection would only be feasible under conditions without the use of the principle of beneficence.

Revised: Type 2 Diabetes

Rashelle Hamilton's¹⁴ HCP diagnosed her with T2DM and began treatment for the condition prior to receiving the bloodwork which would prove Hamilton had diabetes (Engel-Smith, 2021). The violation of the principle of respect for autonomy is the most apparent violation in Hamilton's case. To tell a patient that they have T2DM and then begin to treat them for the condition could have a significant impact on the life plans one

¹³ See section two for the original discussion of this case.

¹⁴ See section three for the original discussion of this case.

makes as well as everything from the execution of those plans to insignificant daily activities. The diagnosis could have caused Hamilton to make decisions she otherwise would not have made.

Similarly, the principle of nonmaleficence was violated because taking a medication that her body does not need can have harmful effects on her. Furthermore, T2DM can be a complicated condition to live with, so the toll taken on Hamilton from the stress was likely high. To diagnose her with diabetes without sufficient scientific evidence would be considered negligence under Beauchamp and Childress's account of the principle of nonmaleficence.

If we give the HCP the benefit of the doubt it could be argued that they were just trying to get a head start on treating something that was negatively impact the patient's quality of life (in other words, they were acting beneficently). However, what makes this HCP's actions different from that of a provider who starts a patient on a course of antibiotics prior to receiving confirmation that the patient has strep throat is that the former is rooted in stigma against fat people and the latter is rooted in a scientifically relevant visual assessment of the patient's throat. Because the provider's judgment was rooted in stigma, it can't be seen as something which was done in "good faith" or in the best interest of the patient.

Revised: Struggling to Breathe

When she suddenly felt like she couldn't breathe, Jane¹⁵ went to the doctor and was informed that her trouble breathing was only because she was fat (Kolata, 2016). When Jane was able to seek care with a different HCP she learned that she actually had several small blood clots in her lungs that were adversely impacting her ability to breathe (Kolata, 2016). To respect Jane's right to autonomy would have required her HCP to perform enough testing to ensure his diagnosis of her condition was accurate so that Jane could make plans for her future and execute those plans. Without accurate information Jane was unable to make adequately informed decisions about what she ought to do. For example, if Jane had taken her HCP's advice and began any kind of exercise routine as a way to lose weight, her life could have been in danger from the blood clots in her lungs. This threat to her life could be considered an unreasonable risk of harm which would mean her HCP also violated the principle of nonmaleficence.

In this case, Jane's HCP violated the principle of beneficence. When her provider agreed to care for her, they took on the specific obligations of beneficence that go along with being her HCP. By treating Jane's concerns as though they are not a big deal and not running tests that they would typically run on others, Jane's HCP violated the principle of beneficence. Like previous cases, the motivation for not treating her concerns with the proper regard stems from a stigma against fat people which manifests in the way the provider cares for their patients.

¹⁵ See section two for the original discussion of this case.

Requirements of Justice

In all three cases the principle of justice can be applied in essentially the same way. To honor the principle of justice as it pertains to fat patients would mean that their interests which are similar to those of non-fat people (ex. receiving care for specific concerns, medical advice, access to proper diagnostic criteria, etc.) and their interests which are relevantly different from non-fat people (ex. avoiding weight stigma from their provider, not being told that dieting is the solution to every concern, etc.) be treated as such. Achieving justice in this setting also requires a general commitment to not deny people care on trivial or undeserved grounds, like the amount of fat a person has on their body. Those are just the most basic requirements of the principle of justice, and yet, they are denied to many fat people in medical settings. In the first case Dr. Carter categorically denies fat patients from accessing medical care through her practice on the (undeserved) grounds that they are fat. The second and third cases show the damage that can result when similar cases are not treated similarly because the diagnostic criteria used was rooted in stigma against fat people rather than legitimate science-based medicine. If the requirements of the principle of justice were followed by HCPs, some of the difficulties fat patients have in accessing quality healthcare could dissipate. Part of achieving justice as it relates to access to care is rooted in removing the negative attitudes that HCPs hold about fat patients. In an effort to prevent these negative attitudes from influencing how fat patients (and other stigmatized groups of people) are treated by HCPs it is crucial to include continued education as a requirement of the revised duty of care.

Preventing Negative Social Attitudes

The final component to be explained in establishing the revised duty of care is the role of education. In the AMA Principles the fifth principle states “a physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated” (*AMA Principles*, 2001). In the revised duty of care, the role of education is critical in meeting the requirements of the four principles previously discussed.

For a HCP to fulfill the principle of respect for autonomy the HCP must be reasonably knowledgeable about the conditions relevant to their patient. This is the case because the primary function of the principle of respect for autonomy is to enable patients to make choices for themselves as it pertains to their healthcare. If their provider is not reasonably knowledgeable, then the patient could be in a situation where they are having to make choices with insufficient or inaccurate information. The role of education applies in similar ways to the remaining three principles. To respect the principle of nonmaleficence knowledge is necessary to prevent HCPs from unintentionally harming their patients. For the principle of beneficence, a physician may not be able to fulfill their specific obligations to patients if they do not have sufficient knowledge about the patient’s condition; it’s improbable that a provider would be able to adequately care for a fat patient without a certain level of understanding about the relationship between fat and health. Lastly, the principle of justice requires HCPs to be well informed in order to avoid providing lower quality care to some patients as opposed to others. For example, if a

HCP has no knowledge about Sickle Cell Trait, Black patients will be impacted significantly more than white patients since 73.1 out of 1,000 Black newborns have Sickle Cell Trait compared to just 3 per 1,000 white newborns (*Incidence of Sickle Cell*, 2020).

Despite the fact that education requirements like those mentioned in the AMA Principles are clearly supported by the revised duty of care, the role of education is understated in the AMA Principles. The commonly held attitudes about fat patients stem from a picture of fat patients as personally responsible for their unhealthy condition, but the research on fatness provides sufficient evidence against those attitudes. Although the list could go on for pages, here are a few of the conclusions from recent research in the field: cardiorespiratory fitness could be a better indicator of mortality risk than obesity (Fogelholm, 2010; Kennedy et al., 2018). The causes of obesity are far more complicated than current attitudes suggest; and it is now known that there is a genetic predisposition to becoming fat or maybe even a causal relationship between genes and fatness (Srivastava et al., 2016; van der Klaauw & Farooqi, 2015). Even when fat patients do lose weight, less than 1 in 5 of them are able to maintain the weight loss *and* many end up gaining back more weight than they lose in the first place (Fildes et al., 2015; Matheson et al., 2012). “The annual probability of patients with simple obesity attaining a normal body weight was only 1 in 124 for women and 1 in 210 for men. The likelihood of attaining normal weight declined with increasing BMI category, with the lowest probably observed for morbidly obese patients” (Fildes et al., 2015). Exposure to this research would most likely reduce the negative attitudes of HCPs because consciousness-raising and exposure to other perspectives are some of the most successful techniques for reducing implicit and explicit biases (FitzGerald et al., 2019).

If HCPs were required to be reasonably well informed about the research needed to provide fat patients with quality care, then the negative attitudes may be less likely to result in harmful behavior towards fat patients. To be clear, the standard of education included in the revised duty of care is not that every HCP must be knowledgeable on all possible conditions any patient of theirs could ever have – such a standard would be extremely burdensome. However, according to the CDC, the prevalence of overweight and obese adults is greater than 40% for American adults and is almost 20% for children (*Adult Obesity Facts*, 2021; *Childhood Obesity Facts*, 2021). So, to expect HCPs to be reasonably well informed on the *actual* causes of fatness, on the *actual* link between fat and health, and on the successful response to overweight and obesity is not an unfair or overly burdensome expectation.

Conclusion

The revisions to the duty of care that have been proposed are an improvement to the currently used model established by the AMA. The primary advantage of the revised duty of care is that it is broadly applicable without being too vague to apply. As it relates to fat patients, this revised duty of care is better able to identify instances where violations of the duty of care occur and to prevent fat patients from experiencing the kinds of harms they currently suffer. Preventing these harms comes not only from the protections granted to fat patients in specific interactions with their HCPs, but also in the ways in which the

revised duty of care attempts to correct negative attitudes prior to the patient being harmed. By modifying the duty of care in this way fat patients will be better cared for and HCPs will be better able to make decisions related to patient care.

SECTION FIVE

THE NEW DUTY OF CARE

Conclusions

The care that fat patients currently receive is categorically different from the care received by most other individuals because of the negative attitudes held by the healthcare providers responsible for caring for fat patients. The duty of care, that should serve to prevent HCP biases from impacting patient treatment, is currently rooted in the American Medical Association's "Principles of Medical Ethics" (*AMA Principles*, 2001). However, these principles are not capable of protecting fat patients from the harms resulting from HCP attitudes. For this reason, the duty of care ought to be revised, and the best account for doing so is Beauchamp and Childress's Principlism. When the duty of care requires HCPs to be reasonably well informed of the scientific research about their patients and provides an ethical framework which is more broadly applicable, the harms experienced by fat patients will be reduced.

To ensure HCPs have a practical framework of principles that can be employed in decision making about patient care, the AMA Principles need to be replaced with a similar formulation of principles. To impose a requirement on providers to read, understand, and apply the theory which results from an analysis of Principlism would likely be too optimistic. There is a valid concern that in simplifying the account of Beauchamp and Childress (2019) the protections they afford to fat patients would be lost. However, when the new education requirements for HCPs are combined with the process of reflective equilibrium that is essential to Principlism, the resulting duty of care would be one that is equally dependent on judgments about specific cases and moral principles. The revised set of principles provided may not be a complete list, as the process of reflective equilibrium may highlight additional requirements that stem from Principlism that are needed to protect fat patients.

The Principles

The first principle would be a requirement that providers are reasonably educated about the information that is relevant to providing care. If, for any reason, an HCP is in a position where they are unable to satisfy this requirement, they would have an obligation to refer the specific patient elsewhere. However, it is important to note that merely not *wanting* to take the time or energy to keep up with research is not the same as being *unable* to do so and would likely be a violation of a provider's duty to uphold the principle of justice and fulfill their specific obligations of beneficence. Ensuring provider education should help to diminish the harms resulting from HCP ignorance about various topics concerning caring for fat patients.

Principle two is rooted in the obligations which stem from respect for autonomy. HCPs would be expected to provide their patients with sufficient information to ensure the patient was able to make and carry out life plans. Furthermore, providers must avoid

imposing their will on patients¹⁶ by informing them about their health, but also assisting them in pursuing their life plans insofar as their health concerns may impact those plans.

The next principle, rooted in nonmaleficence, would require HCPs to adhere to the rules of nonmaleficence proposed by Beauchamp and Childress (2019). Most important of those rules establishes that providers must be impartial in their adherence to the requirements of nonmaleficence. This means that all HCPs must avoid imposing harm or risks of harm to all patients. Lastly, all providers must be aware that even if they did not *intend* to harm their patient, they may still be morally responsible for the harm; especially in cases of unintentional, but careless, negligence.

The requirements of the fourth principle are similar to those of the third principle. HCPs must act in accordance with the rules of beneficence in caring for patients. However, the rules of beneficence allow for partial application of beneficent action where partiality in application could result in fat patients enduring harms similar to those faced currently. For this reason, providers should strive to be impartial in application of beneficent action as is required by the obligations related to specific beneficence. The obligations of specific beneficence would expect impartial application of the principle of beneficence between HCPs and their patients. This is solely because once a provider agrees to care for a patient the relationship between the two is fundamentally different from the relationship between two strangers; therefore, the expectation of beneficence is also different.

The fifth principle aims to establish the grounds on which the second principle and the fourth principle ought to be balanced. Since none of the principles have priority over any other¹⁷, different circumstances will require different applications of the principles. Because of this, there must be a way to balance a patient's interest in their right to autonomy and a provider's interest to care for a patient in the most effective way possible. When these two ideas conflict providers must be prepared to engage with the patient and compromise on treatment plans so that both parties have a reasonable chance of success in achieving their desired outcome. The ultimate goal is to avoid acting paternalistically without giving up on desired health outcomes entirely.

Principle number six accounts for the Principlist conception of justice. Providers are required to treat the needs and interests of all patients with equal consideration and they must avoid denying care to patients on arbitrary grounds. This would mean that HCPs have an obligation to care for all people who need care, who they are able to care for, while showing due respect to the patient's needs, interests, and life plans. These strict requirements of justice ensure that discrimination that is considered legal is prevented on moral grounds.

The last principle is one which allows providers the ability to add to these principles or modify existing ones if it seems necessary based on actual patient

¹⁶ It is important to note there may be exceptions to this general rule in cases where, for example, patients lack cognitive abilities and so paternalistic action may be warranted.

¹⁷ This is the case insofar as one principle is not required to fulfill the obligations proposed by another. For example, it is likely that a provider's ability to fulfill the principles of respect for autonomy, nonmaleficence, beneficence, and justice would all be contingent on a provider being educated enough on the patient's condition.

encounters. However, to justify the addition or modification of principles, there must be reasons to do so which appeal to the general spirit of the Principlist account that has been suggested. This means that any revisions must advance the goals of providing quality care for all people, avoiding causing patients unnecessary harms, and advancing the education of HCPs. If it becomes clear that there is another goal that ought to be included in the revised duty of care, providers are encouraged to look to the principles, as originally laid out by Beauchamp and Childress (2019), for justification.

LIST OF REFERENCES

- Adult Obesity Facts*. (2021, September 30, 2021). U.S. Department of Health and Human Services. <https://www.cdc.gov/obesity/data/adult.html>
- AMA Principles of Medical Ethics*. (2001, June 2001). American Medical Association. <https://www.ama-assn.org/about/publications-newsletters/ama-principles-medical-ethics>
- Anomaly, J. (2012). Is Obesity a Public Health Problem? *Public Health Ethics*, 5(3), 216-221. <https://doi.org/10.1093/phe/phs028>
- Backus, D. W. (1969). The Seven Deadly Sins: Their Meaning and Measurement.
- Beauchamp, T. L., & Childress, J. F. (2019). *Principles of Biomedical Ethics* (Eighth ed.). Oxford University Press.
- Bessey, M., & Lordly, D. (2020). Weight Inclusive Practice: Shifting Focus from Weight to Social Justice. *Canadian Journal of Dietetic Practice and Research*, 81, 127-131. <https://doi.org/10.3148/cjdpr-2019-034>
- Boylan, M. *Hippocrates*. Internet Encyclopedia of Philosophy. <https://iep.utm.edu/hippocra/>
- Brown, I. (2006). Nurses' attitudes towards adult patients who are obese: literature review. *Journal of Advanced Nursing*, 53(2), 221-232. <https://doi.org/10.1111/j.1365-2648.2006.03718.x>
- Bryden, D., & Storey, I. (2011). Duty of care and medical negligence. *Continuing Education in Anaesthesia Critical Care & Pain*, 11(4), 124-127.
- The Cambridge World History of Medical Ethics*. (2009). (R. B. Baker & L. B. McCullough, Eds.). Cambridge University Press.
- Childhood Obesity Facts*. (2021, April 5, 2021). U.S. Department of Health and Human Services. <https://www.cdc.gov/obesity/data/childhood.html>
- Doyal, L. (2001). The Moral Foundation of the Clinical Duties of Care: Needs, Duties and Human Rights. In *Bioethics* (Vol. 15, pp. 520-535). Blackwell Publishers Ltd.
- Eidelson, J. (2022). Yes, You Can Still Be Fired for Being Fat. *Bloomberg*. <https://www.bloomberg.com/news/features/2022-03-15/weight-discrimination-remains-legal-in-most-of-the-u-s>
- Engel-Smith, L. (2021). Fat bias at the doctor's office takes a serious toll. *NC Health News*. <https://www.northcarolinahealthnews.org/2021/02/02/fat-bias-at-the-doctors-office-takes-a-serious-toll/>
- Fildes, A., Charlton, J., Rudisill, C., Littlejohns, P., Prevost, A. T., & Gulliford, M. C. (2015). Probability of an Obese Person Attaining Normal Body Weight: Cohort Study Using Electronic Health Records. *American Journal of Public Health*, 105(9), e54-e59. <https://doi.org/10.2105/AJPH.2015.302773>
- FitzGerald, C., Martin, A., Berner, D., & Hurst, S. (2019). Interventions designed to reduce implicit prejudices and implicit stereotypes in real world contexts: a systematic review. *BMC Psychology*, 7(29). <https://doi.org/10.1186/s40359-019-0299-7>
- Fogelholm, M. (2010). Physical activity, fitness and fatness: relations to mortality, morbidity and disease risk factors. A systematic review. *Obesity Reviews*, 11, 202-221. <https://doi.org/10.1111/j.1467-789X.2009.00653.x>

- Foster, G. D., Wadden, T. A., Makris, A. P., Davidson, D., Sanderson, R. S., Allison, D. B., & Kessler, A. (2003). Primary Care Physicians' Attitudes about Obesity and Its Treatment. *Obesity Research, 11*(10).
- Gordon, A. (2017). Who's fat enough to be fat? <https://medium.com/@thefatshadow/whos-fat-enough-to-be-fat-bd927416821>
- Gordon, A. (2020). *What We Don't Talk About When We Talk About Fat*. Beacon Press.
- Gorman, C. (2016). Could a Few Extra Pounds Help You Live Longer? *Scientific American*. <https://www.scientificamerican.com/article/could-a-few-extra-pounds-help-you-live-longer/>
- Incidence of Sick Cell Trait in the US*. (2020, December 14, 2020). U.S. Department of Health and Human Services. <https://www.cdc.gov/ncbddd/sicklecell/data.html>
- Jacobsen, N. (2009). Dignity violation in health care. *PubMed, 19*(11), 1536-1547. <https://doi.org/10.1177/1049732309349809>
- Kennedy, A. B., Lavie, C. J., & Blair, S. N. (2018). Fitness or Fatness: Which Is More Important? *Journal of the American Medical Association, 319*(3), 231-232.
- Kolata, G. (2016). Why Do Obese Patients Get Worse Care? Many Doctors Don't See Past the Fat. *The New York Times*. <https://www.nytimes.com/2016/09/26/health/obese-patients-health-care.html>
- Malone, J. I., & Hansen, B. C. (2019). Does obesity cause type 2 diabetes mellitus (T2DM)? Or is it the opposite? . *Pediatric Diabetes, 20*, 5-9. <https://doi.org/10.1111/pedi.12787>
- Matheson, E. M., King, D. E., & Everett, C. J. (2012). Healthy Lifestyle Habits and Mortality in Overweight and Obese Individuals. *Journal of the American Board of Family Medicine, 25*(1), 9-15. <https://doi.org/10.3122/jabfm.2012.01.110164>
- Nath, R. (2019). The injustice of fat stigma. *Bioethics, 33*, 577-590. <https://doi.org/10.1111/bioe.12560>
- Pantalone, K. M., Hobbs, T. M., Chagin, K. M., Kong, S. X., Wells, B. J., Kattan, M. W., Bouchard, J., Sakurada, B., Milinovich, A., Weng, W., Bauman, J., Misra-Hebert, A. D., Zimmerman, R. S., & Burguera, B. (2017). Prevalence and recognition of obesity and its associated comorbidities: cross-sectional analysis of electronic health record data from a large US integrated health system. *BMJ Open, 7*, 1-9. <https://doi.org/10.1136/bmjopen-2017-017583>
- Pausé, C. (2017). Borderline: The Ethics of Fat Stigma in Public Health. *Journal of Law, Medicine, and Ethics, 45*(4), 501-517. <https://doi.org/10.1177/1073110517750585>
- Phelan, S. M., Burgess, D. J., Yeazel, M. W., Hellerstedt, W. L., Griffin, J. M., & Ryn, M. v. (2015). Impact of weight bias and stigma on quality of care and outcomes for patients with obesity. *Obesity Reviews, 16*, 319-326. <https://doi.org/10.1111/obr.12266>
- Powell, A. (2012). Obesity? Diabetes? We've been set up. *The Harvard Gazette*. <https://news.harvard.edu/gazette/story/2012/03/the-big-setup/>
- Sabin, J. A., Marini, M., & Nosek, B. A. (2012). Implicit and Explicit Anti-Fat Bias among a Large Sample of Medical Doctors by BMI, Race/Ethnicity and Gender. *PLOS One, 7*(11), 1-7. <https://doi.org/10.1371/journal.pone.0048448>

- Srivastava, A., Srivastava, N., & Mittal, B. (2016). Genetics of Obesity. *Indian Journal of Clinical Biochemistry*, 31(4), 361-371. <https://doi.org/10.1007/s12291-015-0541-x>
- Stoll, L. C. (2019). Fat Is a Social Justice Issue, Too. *Humanity and Society*, 43(4), 421-441. <https://doi.org/10.1177/0160597619832051>
- van der Klaauw, A. A., & Farooqi, S. I. (2015). The Hunger Genes: Pathways to Obesity. *Cell*, 161. <https://doi.org/10.1016/j.cell.2015.03.008>
- Zimmerman, R. (2012). Mass. Doctor Won't Accept New Patients Who Are Obese. <https://www.wbur.org/news/2012/08/30/mass-doctor-wont-accept-new-patients-who-are-obese>

VITA

Originally from Fairfax, Virginia, Anne Merrill attended the University of Tampa where she graduated in 2018 with Bachelor of Arts degrees in Philosophy and Spanish. Prior to graduating, Anne knew she wanted to pursue a graduate degree in Philosophy and found a home at the University of Tennessee, Knoxville. Her research interests include applied ethics, bioethics, and political/social philosophy. She hopes to combine her passions for nonprofit work and philosophy after graduation. She is extremely grateful for the support of her friends and family over the last few years and is excited about what lies ahead.