2026, Volume 58, Issue 10, 810-811, e-ISSN 1938-3800

Family Medicine

NARRATIVE ESSAY

Weight Stigma Internalization in the Medical School Curriculum

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HOW TO CITE: Beliveau C. Weight Stigma Internalization in the Medical School Curriculum. *Fam Med.* 2026;58(10):810-811.
doi: 10.22454/FamMed.2026.794542

FIRST PUBLISHED: November 5, 2026

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I won't tell you my body mass index (BMI), but not because I don't remember it. Every day during my adult outpatient rotation, I compared the number in each patient's chart to my own. How long would it take for my preceptor to bring up the patient's weight? How much would this patient dislike their own body? How fat* was I compared to them, and what did my preceptor secretly think about my size?

I met with my therapist regularly, trying to unpack the mental distress this comparison caused. "What does it mean if you are fatter than them?" she asked me.

I had years of learning about health at every size and weight-neutral medicine; I had a profound and hard-won love of my body. Yet when she asked me this question, I realized that I still feared I was less of a person because of my weight.

In clinic, my preceptor instructed me to bring up a patient's weight at every visit. She consistently counseled patients to lose weight if she felt their BMI was not low enough. She commiserated with patients about her own aspirations for weight loss. She advised patients to reduce their serving sizes (ie, to maintain a calorie deficit). We never screened patients for eating disorders, certainly never those in larger bodies who reported restricting their food intake in hopes of losing weight. Weight was used as a proxy for health and a healthy lifestyle. The complex connections between diet, exercise, genetics, socioeconomic status, and appearance were reduced to the idea that higher BMI equaled lower health.

Weight-centric care is the default in medicine, as medical education teaches that "obesity"** increases all-cause mortality and is an independent risk factor for a wide range of health conditions.[1] These claims are often made without the support of research that robustly controls for confounding factors or rigorously tests hypothesized causal pathways.[1-3] The pervasiveness of antifat bias in the clinic was expected but deeply discouraging all the same.

One day during an annual wellness visit, I met with a patient who wanted to discuss weight loss. Her goals were to improve her health and add more movement to her life. I shared my perspective on weight loss: people often think that losing weight is the best way to get healthy, but the evidence shows that regular movement—preferably joyful—and a balanced diet including fruits and vegetables are far more important for your health than a number on a scale.[2,3] Her face lit up when she mentioned that she used to lift weights, so we made a plan for her to join a gym again. She smiled widely as she told me that she was looking forward to getting stronger.

I presented to my preceptor, and we returned to the exam room to complete the visit. As she finished placing orders, she told the patient, "Just try to lose five pounds by your next visit. Then you will feel much better."

I was disappointed and confused; I had no idea whether that comment had undone all the work the patient and I had done together. If the patient exercised for weight loss, rather than for enjoyment or stress relief, it seemed likely that it would increase her body dissatisfaction and make regular exercise less sustainable in the long-term.

As someone who is involved in weight-inclusive health care, the weight-centric approach of the clinic filled me with alarm. Weight stigma is common among health care providers and causes harms such as chronic stress and care avoidance.[1,4,5] Weight bias and pathologization of fatness are drivers of health care disparities for people in larger bodies, including medical students such as myself.

I gave a lot of consideration to the unintentionally hurtful learning environment fostered by my preceptor. After many emotional conversations with my partner, friends, and parents, I decided not to share feedback with her directly. I felt that she would not appreciate my perspective, and more importantly, I needed to protect myself. I pictured the conversation that we would have, where I would share peer-reviewed articles while my voice wavered and tears rolled down my face, and I knew it would not be an emotionally safe encounter. I needed a strong network of support to resist internalizing everything that my preceptor told her patients. While I wanted to be an advocate for my preceptor's patients, I couldn't imagine it making a difference in that clinic. Two years later, I am still unpacking the ways I was hurt by that rotation.

Yet things are not always so bleak. Months later, in another clinic, a different preceptor and I started a visit together. The patient was going through menopause, and she was worried about recent weight gain. This preceptor expressed understanding. She told the patient, "If your weight is affecting your health in any way, I will let you know. Generally, I like to focus less on weight and more on movement and eating a good balance of foods." Listening to her gentle counseling, I had to blink away tears. I hadn't realized how healing it could be to hear a preceptor talk so kindly and thoughtfully about weight to her patient.

Weight bias is firmly entrenched in US medical practice, and the bodies of patients classified as overweight or obese are frequently pathologized independent of health behaviors and chronic conditions. The stigma and prejudices that patients face can also impact learners. I found myself in a vulnerable space, navigating antifat attitudes in the clinic while trying to advocate for patients. In my future practice, I will encourage students to contribute their own perspectives in patient-centered care. I hope my experience navigating fatphobia as a medical student will help me protect and support my future students.

Notes

*The term "fat" is a value-neutral term preferred by many fat activists.[5]
**The terms "obesity" and "obese" are considered stigmatizing by many higher-weight people as they pathologize body size diversity.

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