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# Rethinking the label "Anti-Obesity Medication"

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Pharmacotherapy approved to support people living with obesity has received significant attention within the scientific, clinical and general public. Clinical trials have reported significant effects of these medications including weight reduction and reduced risk of cardiac events amongst people living with obesity.[1-4]

Of importance is the terminology used to describe these medications, both in scientific and clinical literature and popular media. In scientific literature, they are referred to as "anti-obesity medications". By its very definition, the word "anti" means being opposed to or against something; language used should be supportive rather opposed or against. Empirical evidence has highlighted pervasive weight bias, and the use and impact of stigmatising and harmful language relating to obesity including internalised weight bias, negative emotional response (e.g., disgust) and reduced healthcare engagement.[5-6]

When considering pharmacotherapy treatments for long-term health conditions, terms such as "anti-cancer" or "anti-kidney disease" are typically avoided. Rather, these medications are referred to by their clinical function such as chemotherapy or immunosuppressant. Even where the word anti is used, it typically relates to the function it serves – i.e. anticoagulants instead of "anti-stroke". Exploring the origins of the term chemotherapy, a term coined by Paul Ehrlich, it comes from the idea of using chemicals to treat a disease. It is my opinion that pharmacotherapy for obesity should in a similar vein reflect their function..

Alternative terminology options may, for instance, include 'medications for obesity' that remove the word anti but highlights that these medications are specifically for obesity and not public use or to reflect their function such as 'metatherapy', aligned to the combination used by Ehrlich in coining chemotherapy. Metatherapy combines metabolic and therapy given that these medications affect a range of metabolic pathways associated with glucose metabolism, energy homeostasis, and inflammation.[4]

It is imperative that terminology for treatments avoid further exacerbation of stigma towards the very people who may benefit from them, and that reflects their clinical nature. In doing so, consistent terminology can also highlight, particularly in the case of GLP-1 medications, that these are not for use by people without obesity. In popular media they are often referred to as "weight loss jabs" and "weight loss drugs" that only serves to infer to people who are not clinically eligible that they could be used not for the treatment of obesity - and it may be unsafe to do so. Likewise, alongside media portrayal are concerning reports of their use amongst celebrities or influencers for aesthetic purposes rather than as a clinical treatment and this contributes to misconceptions about the required multidisciplinary support that should be offered as part of any clinical treatment programme.

As such, I call on the scientific and clinical community to cease the use of "anti-obesity medications" and to use terminology aligned to pharmacotherapy for other long-term health conditions. Here I propose either 'medications for obesity' or 'metatherapy', I also call on policy makers, governments, media and other public facing sources for their support in the use of consistent, clinical terminology as well as improved public awareness that these medications are not for popular use, but should only be made available for the patient groups where these medications have been clinically tested and approved.

It is critically important that Governments and health systems approving clinical treatments take adequate steps to educate and intervene with sources that contribute to misconceptions that may lead to use by people who are ineligible. Finally, I call on social media platforms to restrict content that infers the use of these treatments amongst people who do not meet the clinical eligibility criteria for which they have been clinically approved. The continued dissemination of inaccurate information relating to pharmacotherapy for obesity represents a patient and public safety concern; content inferring use of treatments for other health outcomes would not be accepted and neither should it in the case of obesity. Improved public awareness and restriction of their promotion may also support greater access for people living with obesity and diabetes - the clinical populations who the medications have been approved, and for whom there continues to be limited access and supply.

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