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JOURNAL DISCUSSION

Weight Bias in Health Care

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Puhl R, Brownell K. Confronting and coping with weight stigma: an investigation of overweight and obese adults. *Obesity (Silver Spring)*. 2006;14(10):1802-1815.

There is no question that the U.S. medical community faces significant challenges brought on by the dramatic increase in overweight and obesity in the past several decades [1]. The most recent prevalence data indicate that more than two-thirds of all Americans over the age of 20 are currently overweight and nearly 34 percent of them are obese [2]. Despite the fact that the majority of Americans are now medically defined as overweight, stigma against individuals who are obese remains a widespread phenomenon; the reported incidence of weight discrimination has increased by 66 percent since 1995 [3] and is now on par with rates of racial discrimination, especially among overweight women [4]. Unfortunately, health care professionals are not immune to this bias; even those specializing in the field of obesity [5] have been shown to both endorse and display weight bias at an alarming frequency. In fact, one study [6] that investigated attitudes towards individuals who were obese and presumed to be seeking medical care found that physicians viewed patients who were obese as less self-disciplined and more “annoying” and reported less desire to help them than to help thinner patients.

In “Confronting and Coping with Weight Stigma: An Investigation of Overweight and Obese Adults,” Puhl and Brownell investigate the myriad sources, correlates, and consequences of weight stigma in nearly 3,000 adults who were overweight and obese [7]. Using one sample of more than 2,000 women (with a mean BMI of 37.6) and a second sample of more than 200 adult men and women matched for age and BMI, the authors asked the participants, all of whom were members of a weight-loss support organization, about their experiences of weight-based stigmatization, coping responses to stigmatizing situations, psychological functioning, and eating behaviors [7].

To assess weight-based stigmatization, participants completed a modified version of Myer and Rosen’s Stigmatizing Situations Inventory, in which they ranked the frequency of numerous stigmatizing situations on a four-point Likert scale from 0 (never) to 3 (multiple times). To assess sources of possible weight stigma, participants were provided a list of 22 types of individuals, ranging from spouses to servers at restaurants. Respondents indicated if, and to what extent, the listed individuals had been sources of weight-based stigmatization (again, on a four-point

Likert scale from 0 to 3). They also self-reported demographic information, as well as height and weight, from which the researchers calculated BMI.

Results indicated that weight-based stigmatization was a common experience, especially instances such as “others making negative assumptions” (for instance, expecting poorer performance due to one’s weight), “nasty comments from children,” “physical barriers and obstacles,” and, notably, “inappropriate comments from doctors.” In fact, over half of the sample reported that they had experienced “inappropriate” comments from doctors regarding their weight at some point in their lives.

When asked about the interpersonal sources of weight stigma, participants in sample 1 cited doctors as the second most common source (reported by 69 percent), preceded only by family members. Similar results were obtained in sample 2; women cited doctors as the most common source of weight bias, while men cited doctors as the second most frequent source (following classmates). Taken together, these data reveal that weight bias among health care professionals is not only present, but prevalent.

Puhl and Brownell also assessed various coping strategies employed in response to weight stigmatization (using a modified version of Myers and Rosen’s Coping Responses Inventory). Participants were provided with 99 possible coping methods and asked to indicate if, and to what extent, they employed various coping methods in response to an experience of weight bias.

Notably, 79 percent of respondents from sample 1 reported using food to cope with weight stigma on multiple occasions; 90 percent reported using food to cope with weight bias at least one time in their lives. Similarly, in the matched sample, 80 percent of “both women and men reported coping with stigma by eating more food on at least one occasion” [7]. In fact, using food to cope with experiences of weight bias was reported by both sexes to be one of the most frequently employed coping strategies [7]. A startling three-quarters of participants also reported “refusing to diet” as a means of coping.

Puhl and Brownell’s article indicates that health care professionals are common sources of stigmatization for individuals who are overweight. Furthermore, a frequent coping strategy involved either consuming extra calories or refusing to diet. These data suggest that, despite their best intentions, health care professionals who display weight bias may, in fact, be helping to perpetuate our nation’s obesity crisis.

Do perceptions of weight bias reported by the subjects in Puhl’s and Brownell’s study reflect health professionals’ actual attitudes or behaviors? The findings in the literature spanning several decades indicate that they do. Numerous studies have documented negative attitudes and beliefs about individuals who are obese among medical students, physicians, nurses, mental health professionals, and dietitians [6, 8-12]. For example, studies have shown that medical students believe that patients who

are obese lack self-control, are less likely to adhere to treatment, and are more “sloppy,” “unsuccessful,” and “unpleasant” than thinner patients [8, 13, 14]. In one study, medical students reported that patients who were morbidly obese were the most common target of derogatory humor among attending physicians, residents, and students [15]. In another study, 24 percent of nurses reported that they felt “repulsed” by patients who were obese and 12 percent reported that they did not want to touch these patients [11], while another study found that 31 percent to 42 percent of nurses indicated that they would prefer not to treat patients who are obese [12].

Weight bias is also prevalent in health care in more subtle ways. For example, many health care facilities are ill-equipped to effectively and accurately treat patients who are obese. In a study of bariatric patients, many reported dissatisfaction with ill-fitting hospital gowns, small blood pressure cuffs, and examination and x-ray tables not equipped to support their weight [16]. In fact, in a study by Amy et al., 91 percent of health care professionals reported that their facility did not have scales readily available for patients over 350 pounds, 79 percent of facilities did not have gowns sized for larger patients, more than half did not have armless chairs, and 40 percent did not have exam tables that could accommodate a patient who was obese [17]. Puhl and Brownell found that being confronted with physical barriers and obstacles was ranked third among stigmatizing situations; the injurious effect of this type of indirect weight discrimination must be noted because it is common and easily overlooked [7].

Compounding the fact that individuals who are overweight and obese might be less likely to seek medical care [17-19] are the myriad psychological consequences that can result from weight bias. Individuals who have been stigmatized due to their weight report increased vulnerability to depression, anxiety, body image disturbance, binge eating, decreased self-esteem, and suicidality [20, 21]. Despite the psychological correlates associated with weight stigmatization, Puhl and Brownell found that for the men in the sample, receiving inappropriate comments from doctors regarding their weight was *inversely* associated with seeking therapy.

The extant literature shows that the experience of weight stigmatization can give rise to a host of negative outcomes, both physical and psychological. Those in the medical community can play an important role in attenuating the adverse impact of weight bias among patients who are overweight and obese. Research and teaching should better attend to the treatment of such individuals, and medical facilities should be better equipped for them. Perhaps more pressing is the need for awareness among the medical community of the pervasive weight bias constantly faced by overweight individuals. Our physicians, residents, medical students, nurses, and medical researchers must confront the deleterious effects of our country’s rampant weight bias and make substantive efforts to be a part of the solution.

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