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Weight Bias in Healthcare: An Investigation of Impact on Obesity

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
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Walden University
2018

Abstract

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MSN, Gonzaga University, 2013

ADN, Temple College, 1999

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

More than two-thirds of Americans are obese or overweight. Obesity rates have risen to an epidemic level, contributing to health inequalities and leading to reduced health-related quality of life. When obese and overweight persons face weight bias by health care providers, fragmented care may occur. Ensuring positive relationships with healthcare providers is important in helping those who are obese or overweight. The purpose of this project was to understand the factors that contribute to negative weight bias in the provider–patient relationship and to identify the most effective interventions that would reduce stigmatizing attitudes and support self-awareness, acceptance, and resolution for both patient and provider. The theoretical foundations of cultural humility and self-appraisal in interpersonal relations were applied to inform this project. The Cochrane Handbook for Systematic Reviews framed this systematic literature review. Additionally, Melnyk's levels of evidence was used to evaluate each article. Articles for inclusion were limited to those published no earlier than 2013, full text available, English language, and peer-reviewed. The search identified 102 articles, of which 26 were selected for the final review. Five articles met the criteria for Level VII (opinions of experts), 18 were Level VI (qualitative studies), 1 was a Level V (qualitative review), and 2 were Level 1 (systematic review). The analysis of evidence clarified the issues related to weight bias and supported recommendations for nursing practice improvement in upholding the dignity of all persons with regard to weight. Nurses can pioneer positive social change by becoming role models who advocate for equality in healthcare delivery for persons who are obese or overweight.

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Section 1: Nature of the Project

Introduction

Obesity is prevalent in the United States and has also become a prominent global health concern (Alberga, 2016). The etiology of obesity is multifactorial. However, the impact of a significant contributive factor, weight bias from the public and healthcare providers, has been neglected and requires further study. Weight bias, whether implicit or explicit, includes stereotyping and discrimination of those with excess weight. This discrimination remains the only tolerable form of judgment that is socially acceptable today. Nursing healthcare professionals are not innocent of the behavior even though they may not be aware of it. Social justice for the obese is required and care delivery must be transformed so that it is free of prejudice and perceived hierarchies. Health care provided to the obese population offers a chance for the nursing discipline to establish an exemplary social change model that exhibits equality of human rights and health management, regardless of body size.

Problem Statement

Local Nursing Practice Problem

Weight is a health problem that tends to worsen with time. The bias experienced by obese patients raises health disparities by reducing patient participation in key preventative health and wellness care, diverting acceptability of advisement of healthcare interventions, and lessening health-related quality of life (QoL) measures. This problem, weight bias, is focal to nursing practice in Texas because the number of obese and overweight patients exceeds that of patients in the normal weight category.

Local Relevance

The rate of adult obesity, 18 years+, in Texas has increased from 21.7% in 2000 to 33.7% in present year. Thus, Texas has the eighth highest rate of adult obesity in the United States (Trust for America's Health and the Robert Wood Johnson Foundation [RWJF], 2017). When combined with overweight status, the percentage of adult patients with excess weight in Texas rises to an average of 68; in essence, more than two of every three individuals exhibit a weight condition (Centers for Disease Control and Prevention website [CDC], n.d.). Children, 0-17 years, are not excluded from the crisis. Nearly 15% of those 4 years and under are obese in Texas (RWJF, 2017)., If left unaddressed, weight bias can increase the deterioration of general health associated with obesity.

Significance to Nursing Practice with Awareness of the Target Population

Intense study of this unjust inequality and most research projects are undertaken to benefit the accessible population in order to be able to generalize to the target population. Generalizability cannot occur unless the accessible population is represented by the sampled population (if sampling occurs, for example, in research). Moreover, the accessible population must itself also be representative of the target population (Grove, Burns, & Gray, 2013). In the study of weight bias, observed is it being a problem on a global epidemic level as well as a national epidemic level that carries negative impact on nursing practice throughout the United States (DeBarr & Pettit, 2016). The obese and overweight population in Texas is not different from the target population, the United States. Two-thirds of Americans carry excess weight and provider bias is acknowledged as a central contributory aspect of this condition (Nazione, 2015). A doctoral project that

can shed light on the influence of weight bias, both locally and to the national obese population, would be significant for the advancement of nursing.

Purpose Statement

Gap in Practice

Weight bias is found repeatedly present in practice with substantial results lived out by obese patients (Puhl et al., 2015). Occurrences of blame and frustration for the excess weight implied by healthcare professionals are not uncommon (Lee, Ata, & Brannick, 2014). Compounding this documented problem is the failure to address it; provider self-recognition of stigmatizing behavior with identification of interventions most successful for altering the behavior is called for (Alberga et al., 2016; Lee et al., 2014; Nazione, 2015; Puhl et al., 2015). Study aimed at discovery of the etiology of provider beliefs may guide the construct of interventions to one more rewarding. Ascertaining if the thoughts and actions of the provider exhibiting the bias are nurtured from societal components or are more innate is important to the continued design of the research. Having awareness of the detriment of weight bias in healthcare, the nursing profession is challenged to extract and reshape its precursor. Taking such action will thereby transform the care of the obese and overweight population.

Practice-Focused Questions

To offer strategies to revamp nursing practice, the practice-focused question is two-part as displayed here:

1. Among nursing professionals, what are the antecedents associated with treating obese patients that contribute to negative implicit weight bias in the provider-patient relationship?

2. Given the significant impact of health inequalities, what are the most effective weight bias interventions that would inspire recognition of the bias and reduce the stigmatizing attitudes in the nursing field?

Potential to Address the Gap in Practice

Valuable DNP doctoral projects may be carried out as evaluations of quality improvement projects, staff education projects, the development of clinical practice guidelines, systematic reviews of the literature, and more (Walden University, 2017). The purpose of a systematic review is to summarize and synthesize the existing literature apposite to a sole problem in need of unravelling (Walden University, n.d.; Walden University, 2017). Regardless of the literature being limited or sparsely related, the literature review will provide a critical analysis of the present level of knowledge and further validate the topic. Given that weight bias has been established as a true and measurable nursing practice problem, completion of this systematic review can reveal, exhaustively and without bias, the gaps in practice, as shown above by limited research. These gaps have proven scientifically how common the problem is, its detriment to healthcare and society, and the need for fresh research whose findings would be suitable to alter the protocols specific for the nursing care of the obese.

Nature of the Doctoral Project

Sources of Evidence

Investigations into the harms of weight bias and interventions to change provider conduct are scarce. The evidence gathered to address the purpose of this doctoral project included published works in scholarly sources as well as gray literature. Being a systematic review, the intent was not to limit the search to a meta-analysis focused on quantitative studies nor a meta-synthesis focused on qualitative studies. The purpose was to evaluate both forms of studies, qualitative and quantitative, and yield an integrated review.

Approach to Organization and Analysis of Evidence

The definitive goal of a systematic review is to present unbiased results. Being cognizant of such, the organizational phase of the review was comprised of establishing the scope, formulating the foci of inquisition with attention given to inclusion and exclusion criteria, and performing an extensive search for suitable studies (Walden University, 2017). Analysis began with appraisal of the quality of each study. Following was the assembling of the degree of current knowledge revealed in regard to the problem. Finally, extrapolation and synthesis of the findings, with interpretation of relevance, are presented (Melnyk & Fineout-Overholt, 2014; Walden University, 2017).

Concise Statement of Relationship of Anticipated Findings to Gap-in-Practice

The findings of the systematic review are expected to fill the gap in nursing practice because of the review's capacity to bring scientific attention to the discriminatory effects of weight bias. Likewise shown is the need for swift educational intervention to

bring about self-awareness among providers and revolutionary changes in their care of the obese that will avoid destructive stigmatization.

Significance

Weight bias is a catalyst of obesity (Latner, Barile, Durso, & O'Brien, 2014; Luck-Sikorski, Riedel-Heller, & Phelan, 2017; Nazione, 2015). Those affected by obesity represent a multiplicity of persons. Health promotion efforts have had little to no impact on obesity for decades; to change the current trajectory of obesity it may be necessary to re-focus upon psychosocial well-being (Milligan, 2014). Noted, being a recipient of weight bias is a major contributory factor to the unhealthy psyche of the obese patient.

Stakeholders

Direct stakeholders include the patients themselves and their preventable chronic co-morbidities that increase health care costs thereby creating indirect stakeholders (CDC, n.d.). The obese spend 42% more on healthcare costs than adults of normal weight (RWJF, 2017). The morbidly obese patients' per capita healthcare costs are 81% higher than normal weight adults (RWJF, 2017). Expenditures in the United States on obesity are now $1 of every $5 spent and averages more than $190 billion annually (Harvard University [HU], 2018). Clinics and hospitals are inundated with the care needs of the obese; these needs dominate the overall patient population. Healthcare providers must, without fail, exhibit ample compassion, openness, and receptivity to those of larger body size on a daily basis. Otherwise, the epidemic continues to grow.

Resources utilized for care of obesity are significant on the national level. It is unclear how long these allocations will last. Indirect stakeholders include employers,

insurance providers, and schools. Given the obese population, employers locally and nationally face loss of work value due to increased short-term absences, long-term disabilities, and worked performed at less than optimal capacity (HU, 2018). Furthermore, employers must pay higher workers' compensation rates and life insurance premiums for the obese (HU, 2018). Insurance benefits paid out for the obese surpass that of normal weight patients; however, the premiums charged for obese patients are covered by the Affordable Care Act which does not allow insurance companies to require a higher health premium for a preexisting condition. Schools are also impacted by obesity as obese and overweight children miss more days than normal weight children due to their co-illnesses with these children also experiencing teasing, social isolation, and depression (CDC, n.d.).

As has been established here, weight bias contributes to the obesity problem. Change agents are necessary to begin influencing the behaviors of care providers and eventually, the public. By 2030, obesity in America is predicted to increase to new heights and involve 42% of our national population (HU, 2018). If innovative research is not performed to change this trend, the above stakeholders (both the obese and those indirectly affected) will continue to bear the consequences.

Potential Contributions to Nursing Practice

The heart of nursing practice is that of professionalism, which means consistent compassion and respect for the dignity, worth, and uniqueness of every individual without regard to cultural diversity whether ethnicity, socioeconomic status, beliefs or religion, disparities in health, lifestyles, privileges, or personal attributes (Grace, 2014; Foronda, Baptiste, Reinholdt, & Ousman, 2016). Discrimination in the form of weight bias is not in

alignment with any of the above. The advancement of self and the discipline of nursing are the ethical duty of every nurse (Grace, 2014). This doctoral project is expected to contribute to the integrity of the profession by accenting the presence of weight bias, including implicit acts and their negative outcomes on the obese patient, as well as the condition of obesity in its present epidemic state. Such awareness can inspire further nursing research and result in implications for constructive nursing practice changes.

Transferability

The generalizability and transferability of the systematic review findings are robust due to the accessible and target populations conforming one to the other. Eligibility criteria of obesity are one and the same, whether local to Texas or on a national level. This strengthens external validity. Usefulness of results for evidence-based practice can be applied to the general population of the United States with the shared characteristic of larger body size as defined by obesity and overweight. As noted above, the findings would apply to two-thirds of the American population.

Implications for Positive Social Change

As above, weight discrimination is the single social injustice that is still tolerated. The bias suffered by the obese reduce QoL, decrease the use of preventative healthcare and interventions advised for lifestyle changes, increase co-illnesses and mortality rates, and increase financial burdens on the patient and the nation. Given the wide-ranging social respect for healthcare providers, they have a unique opportunity to change the social discourse by showing exemplary behavior and applying practices that are supported by evidence-based science. The epitome of Walden University's positive social change

mission is to draw much needed attention to the prejudice, stereotyping, and discrimination of the obese in both the public and medical professional realms and to step up to stop these behaviors n the health care arena is (Walden University, 2012).

Summary

Section 1 has provided the reader with an introduction to the topic of weight bias as the focus of the DNP doctoral project with a brief implication of its social injustice requisite of change. Weight bias is found present and problematic in local nursing practice; local relevance is clarified with science-based documentation. Explained in brief is the significant impact of weight bias on obesity that takes place within nursing practice. The purpose of altering care of the obese by addressing weight bias is presented as the gap in practice needing to be addressed while the project's potential to do so is spelled out. Two guiding practice-focused questions are presented; sources of evidence and approach to such are laconically reviewed. Stakeholders effected by outlays of weight bias and obesity are explained; budding contributions anticipated to improve obesity disease management in the local nursing practice with transferability to the discipline as a whole are discussed. The positive social change that is expected is discussed; reducing weight discrimination defines this social change and is significant to the project's endeavors. A comprehensive arrangement of the background and context of the DNP doctoral project follows this segment.

Section 2: Background and Context

Introduction

Healthcare provider weight biases are a chief cause of health inequalities (Lee et al., 2014; Nazione, 2015; Nutter et al., 2016). Obese and overweight patients consist of more than two-thirds of Americans and are foremost in the vulnerable population; nevertheless, these persons continue to be judged and discriminated against (Nazione, 2015). In this project, a two-part practice-focused query investigated the antecedents that contribute to implicit weight bias in the provider-patient relationship as well as in the discovery of the most effective weight bias interventions. The purpose of this project was to make nursing providers aware of the indirect yet harmful actions and how to reduce them. In this section, the theoretical background, its relevance to nursing practice with regard to local context, and the role of the DNP candidate are examined.

Concepts, Models, and Theories

Rationale

This process by which this project was conducted is in alignment with the paradigm of positivism: orderly, objective, and preserving of a fixed design (Malterud, 2016; Ward, Hoare, & Gott, 2015). Positivism is fueled by a reductionist perspective or an impartial examination of the components of the phenomena (Ward et al., 2015). Applying this methodology yields an unprejudiced identification of the relationship of the antecedents that are linked to the provider conduct resulting in implicit weight bias. In addition, the resultant disparities associated to weight bias (lesser quality of and reception to healthcare management) are scrutinized as well as the effectiveness of a population-

focused intervention. The theoretical contributions of Madeleine Leininger, Hildegard Peplau, and B. M. Bass were selected to inform this project as the underpinnings of each theorists' works consisted of implementing an external study approach of the phenomenon at hand, subsequently maintaining an independent, objective relationship with the phenomenon thereby displaying positivist perspective. Moreover, the similarity and pertinence of their phenomena to the issue of weight bias is considerable.

Leininger, the founder of transcultural nursing, focuses on the need to emulate cultural humility in each professional interaction. The context of culture is noted as all-encompassing of diversity. Living with obesity is a deviation from the social norm (Foronda et al., 2015). According to Peplau's nursing theory, one's own beliefs driving their behaviors must be explored first; this is integral to establishing an effective interpersonal relationship with the patient. Central to this project is the nursing provider's self-realization of behavior that is the product of implicit weight bias. Once realized, it can then be remedied. Bass's concept of transformational leadership provides motivation to its followers (Kovjanic, Schuh, & Jonas, 2013). Inspiring nursing providers to become transformational leaders with respect to the care of the obese patient is central to the resolution of the problem of weight bias being explored in this study.

Synthesis

Madeleine Leininger. Leininger offers nursing a middle range theory that emphasizes care that is culturally congruent with the beliefs, practices, and values of the patient (Leininger, 1981). The basic tenets of her theory include care and caring that incorporate cultural diversity, social structure, origin preservation, differentiation

accommodation, and repatterning of behavior (Leininger, 2001). For Leininger, nursing professionals can bring about positive change only when they are astute in assessing and intertwining the personal, social, environmental, and cultural needs of the patient into the care plan (Leininger, 1995). The call for cultural mindfulness and a receptive, egoless approach to the patient by Leininger supports this project's goal.

Hildegard Peplau. Peplau provided the nursing discipline with communication awareness. Being observant to both the direct and indirect messages sent to the patient is the highpoint of her message. Six roles the nurse will play are dissected in combination with three ensuing and overlapping phases of the nurse-patient relationship; the relevance of each element to the ongoing appraisal of self, patient, and the interrelationship quality being integral (Peplau, 1988). The epitome of this project is cognizance and amendment of the implicit messages sent during patient interactions.

B. M. Bass. Transformational leadership is the underpinning of the concept provided by Bass. Bass argued four specific dimensions in his theory compulsory for change (Bass, 1985). Motivation of others takes place after overcoming self-interest for Bass; futuristic optimism follows (Bass, 1985). Acting as a positive role model builds confidence and commits people to action (Bass, 1985). Bass employs examples of transformational leadership used by the U.S. military in the Reserve Officers Training Corps (ROTC) (Bass, 1985). Here, the conceptualization of Bass aligns with inspiring nursing providers to displace all egotism and instill pride in each patient. Through personal encouragement, shared patient goals become accomplishments.

Clarification of Terms

Giving the reader precision on significant terms in this project is chief to its clear understanding. The terms below may have multiple meanings outside of this study.

Weight bias, in this text, is a form of stigma characterized by negative attitudes, blame, and relational distancing or a lesser level of rapport leading to the imposition of detrimental effects on the health and wellness of persons of overweight or obese status (Alberga et al., 2016; Nutter et al, 2016).

Obese is a measure of body mass index (BMI) of 30 kg/m2 or more; overweight is defined as a BMI of 25-29.9 kg/m2. Larger body size includes both levels of BMI; hence, a person with a BMI equal to or greater than 25 qualifies as larger-sized (CDC, n.d.).

Cultural humility is not cultural competency; the vital differentiation is the attainment of self-awareness being a must in cultural humility (Foronda et al., 2015). Comprehending that we are not ever experts in the norms of people diverse from ourselves is key (Isaacson, 2014). When wisdom prevails and humility surfaces, the provider accepts the above and grasps that the more we are exposed to patients who differ from ourselves, the more we are able to see how much we simply do not know. An other-oriented interpersonal stance that lacks self-focus and superiority, includes self-reflection and critique, and provides respect for cultural experiences and backgrounds is what defines cultural humility (Foronda et al., 2015).

Relevance to Nursing Practice

Brief History of the Broader Problem

Obesity is a disease that neither medicine nor nursing have been able to alter the path of. For decades, a plethora of tactics from numerous disciplines as well as state and national levels have tried and failed to make a positive impact. The United States, being grouped together with other countries of high income, wears the crown for the country with the highest rate of obesity and overweight. Since the 1980s, adult obesity has more than doubled and childhood obesity has tripled in America (Harvard University, n.d.). Obesity is second only to tobacco in the number of deaths it causes annually for persons 70 years of age and under (Harvard University, n.d.). There are no signs of the obesity rate stopping; one in three Americans are obese today with an estimate of 50% of our population being obese by 2030 (Harvard University, n.d.). Discovery of foremost influential factors linked to the expansion of the disease is elemental to shifting its discourse. As the broader problem of this project, obesity effects nursing practice and nursing practice is affected by obesity.

Current State of Nursing Practice

The discipline of nursing stands proud on its steadfast commitment to maintaining the dignity and worth of each patient regardless of his or her attributes. Nonetheless, weight bias exists across all domains, including that of nursing (Wakefield & Feo, 2017). Negative attitudes in the care of the obese, whether expressed or implied, influence weight-based disparities in the health and wellness of the individual (Nutter et al., 2016). Central to health inequalities are biases from providers (Nazione, 2015; Wakefield &

Feo, 2017). Nursing professionals are not immune; weight bias can be manifested through the nurse delivering better care to a thin person than an obese person. Doing so unintentionally, the nurse who may have no sentient negative attitude toward obesity has displayed an implicit bias (Tomiyama et al., 2015). Self-awareness is imperative; lack of self-assessment leads to hindering the care of the obese through development of cultural incompetence (Yeager & Bauer-Wu, 2013). Nursing practice has had little accomplished in the acknowledgment, scrutiny, and resolution of this phenomenon (Puhl et al., 2015).

Obese patients are subjected to daily discrimination living in a society where weight bias remains socially acceptable. Often ignored is the stigma placed on obese persons. Rarely challenged is this prejudice in the public realm; however, nurses can instigate change and create a zone where obese people may expect consistent respect through nurses identifying the biases and intervening to cease its occurrences within the discipline. Adversely affecting their health outcomes, patients who feel judged or discriminated upon by healthcare professionals are less likely to adhere to treatment or seek preventive services. Nurses can become the change agents needed to enforce a healthcare approach absent of discrimination and robust in building rapport with the obese. Recognizing and addressing weight bias is a nursing practice improvement obligation in compliance with social justice.

Previous Standard Practices

Available studies and successful interventions exist in scarcity regarding weight bias (Lee et al., 2014). The approach of teaching cultural competency regarding obesity compassion has not been successful as the training bred stereotyping of people by

application of a list of common traits (Nazione, 2015). Obesity is an individual-level trait

that must be approached by the nursing provider with cultural unpretentiousness

(Nazione, 2015). Created for assessing attitudes and obesity knowledge have been a

limited number of tools; the Fat Phobia scale (F-scale), the Beliefs About Obese People

scale (BAOP), the Attitudes Toward Obese Persons (ATOP) scale, and the Obesity

Knowledge (OK) scale are examples of such tools (DeBarr & Pettit, 2016;

Ratanapichayachai, Paothong, & Phattharayuttawat, 2017). However, neither of the

above obesity assessment tools have been incorporated into obesity management practice

guidelines.

International weight bias summits are beginning to take form to address the gaps

in practices with agendas inclusive of research presentation and solutions proposed that

will have the greatest bearing on the phenomena. Discovered at a recent summit in

Canada was the lack of consensus on fruitful obesity language, the inclusion of the

testimonials of obese persons in all research and knowledge, the need for

interdisciplinary collaboration and weight sensitivity training, and the commencement of

regulations with legal punishment for those in the public sector who impose weight-bias

on individuals (Alberga et al., 2016). These are the beginnings of much work to be done.

Filling Gaps in Practice through the Doctoral Project

With a two-part practice-focused question addressed, this doctoral project has

brought light to the deficiency within nursing to consistently identify all forms of weight

bias, the duty of the nurse to exercise self-awareness and critique to achieve cultural

humility, and the obligation of the discipline to incorporate the most efficacious

interventions to bridge the gap between the obese patient and excellence of nursing care without associated discrimination. Achievement of the above will reduce or eliminate the known physical and psychological consequences experienced by persons of obesity when stigmatized or judged based on their appearances. Improving the quality of healthcare received by nurses will improve the QoL for those of larger size.

<div align="center">**Local Background and Context**</div>

Summary of Local Evidence

A remarkable increase in obesity rates among all sectors of people living in the state of Texas has occurred since 1980. There are no exceptions to its growth; the expansion includes all ethnicities, socioeconomic statuses, education levels, ages, and gender (Texas Department of State Health Services [TDSHS], 2014). The prevalence of both obese adults and obese children of high school age is higher in percentage in Texas than in the United States overall (TDSHS, 2014). It is established that persons of obesity who do not build a rapport with their provider due to distancing, stigmatizing, or feelings of prejudices suffer increases in depression and eating disorders, avoidance of physical activity and preventive healthcare, and increased risk of mortality (Alberga et al., 2016). Providers in Texas are not resistant to weight bias; nevertheless, the time to initiate such is never better.

Institutional Context

The effects of weight bias on obesity reach into all demographics, community settings, healthcare institutions, educational arenas, occupational environments, life and health insurance settings, and most state programs. Reducing or eliminating weight bias

in Texas has substantial potential as it is evinced to fuel the obesity epidemic. Altering

the care received by people living with obesity through identification and intervention of

this problem will have a downstream benefit to an abundant amount of Texas institutions.

As two in three adults in Texas are of larger size, virtually no institutional atmosphere

exists in the state that is absent of obese clientele (CDC, n.d.).

Locally Used Terms or Operational Processes

Noted is there are no variances in local terms or operational processes that are

relevant to the understanding of this doctoral project. Generalizability of the project's

findings to the target populations consistent of nursing professionals and obese patients

outside of the state of Texas is essentially limitless. As the objective of the project has

been to advocate for an evidence-based clarification of an approach to an illness, the

design and analysis is pertinent to a local problem that is widespread to a national level.

Applicable State or Federal Contexts

State settings that provide direct or indirect healthcare services or advisements

have relationship to this problem. As above, obesity is rampant in Texas. Hence, all state

healthcare entities will be affected by outcomes that sway the course of obesity. Of

simply one example is the Texas Women, Infants, and Children (WIC) program as more

than 15% of its enrolled children between two and four years of age are obese (TDSHS,

2014). WIC can improve its health impact with addressing weight bias. Parents of obese

children who do not feel discriminated against will be more likely to follow healthcare

advisements.

The federal contexts that have relevance to this project parallel that of the state's. Any federal arena that guides actions in national healthcare has association with obesity. Refining obesity as a product of weight bias recognition holds the prospect for betterment of the health of the country. With aim for high potential is a display of what one nurse is capable of as a change agent at the federal level. Dr. Carol Romano is a nurse serving as Acting Chief of Staff for the Office of the Surgeon General. The outstanding national healthcare accomplishments of Dr. Romano over several years are vast. Some of her many tasks in her position today, in addition to advising for the Office of the Surgeon General, include the development of educational curriculums, authoring of books, designing of national conferences, service on editorial boards, and granting of research funds (Romano, 2011). As weight bias initiatives reach national levels, a powerful nursing professional such as Dr. Romano could offer extensive promotion and networking opportunities as obesity is a factor in a large number of federal programs.

Role of the DNP student

Professional Context and Relationship to Doctoral Project

Professionally, I am presently employed in a Bariatric specialty. It is my affinity to care for the vulnerable, most specifically, persons of overweight and obesity. As the last socially acceptable form of discrimination, the larger size person is at risk for being the recipient of harmful words or suggestions each time they leave their home. Healthcare professionals are human and imperfect; nonetheless, long-standing damage can be inflicted upon a person of diversity such as the obese without even the knowledge of the contributor. Weight bias is more commonly implicit and unintentional. Self-recognition

and rectification of the action is lacking in nursing professionals. My relationship to this project is witnessing firsthand the physical and psychological injuries of the obese specific to weight bias.

Role in the Doctoral Project

In expansion of my relationship to the topic, my professional long-term goals include enhancing the self-confidence of the obese in efforts to establish trusting relationships and inspire alterations in their pathways of health. Weight bias in healthcare is a proven issue; however, it is rarely addressed. Specific to this, obese persons have fear and feel shame when interacting with healthcare professionals as they lack assurance of not being judged. My role is to stimulate addressing a problem that has essentially not been addressed previously. A summary and synthesis of the evidence with identification of the most appropriate tactic for its intervention has taken place.

Motivation and Affective Perspectives

Collaborating with other healthcare professionals and public officials to ensure overweight and obese persons do not experience discrimination is a vision I hold. Personally, I am neither overweight nor obese nor are my family members. Nonetheless, understanding the obese population is not able to hide their addiction or dysfunction as can others who have assorted challenges is imperative in the ability to offer unrelenting compassion. Having the knowledge of obesity presenting as an illness resulted from genetics and environment, I feel it is my purpose to advocate for permanent change in their environment, equally what they can control and that which they cannot. My practice allows me to inspire changes in their environment that they can control. My professional

role gives me the opportunity to make changes in their environment which they cannot control (weight bias).

Potential Biases

The objective of this project has been the provision of an unbiased review of bias. Potential biases may be visions of patients expressing situations in which they experienced discrimination from other healthcare professionals. In my practical experience, weight bias is most common from primary care providers. These personal involvements will be irrelevant to my findings as the problem I have selected is framed within a systematic inquiry that has warranted numerous suppositions.

<div align="center">

Summary

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Section 2 has provided the reader with an in-depth look into the background and context of the doctoral project with rationale for the methodology selected for project guidance. The theoretical contributions of Hildegard Peplau, Madeleine Leininger, and B.M. Bass are observed and explained as to their pertinence to weight bias investigation. An examination of nursing practice relevance is appreciated; the current state of practice demonstrates gaps between the broad presence of weight bias in the discipline and lack of nursing self-acknowledgement as well as avoidance of taking action to identify how to resolve this proven problem (weight bias) that is affecting care of the obese patients. Local evidence, specific to the state of Texas, is displayed. Federal context is included with an example of how weight bias and obesity affect the Women, Infants, and Children program. Answering why this topic is chosen is conveyed in the motivation and inspiration of the DNP student. An exhibition of evidence collection and analysis follows.

Section 3: Collection and Analysis of Evidence

Introduction

Weight bias is a problem chronically experienced by the obese and overweight population in healthcare as well as in the public realm. Healthcare providers, including nursing professionals, are not exempt to inflicting implicit and explicit weight bias on their patients. The obese are the last remaining diversity in which discrimination received is not shunned. As a result, the obese patient is less likely to attain optimal health due to reduced participation in preventive medicine, doubtful adherence to healthcare advisements, and resultant increase in the co-morbidities associated with obesity. The purpose of this doctoral project has been to unearth the incidences of implicit weight bias, identify the antecedents of the behavior, enhance self-recognition of the provider, and ascertain the most efficacious interventions to diminish or absolve the conduct thereby improving nursing etiquette and altering the course of obesity through a systematic review of the literature.

A methodology inclusive of cultural humility as reviewed in section 2 was utilized. Intra- and interprofessional theories were applied; scrutiny of the relevance of obesity discrimination to nursing practice with emphasis on local evidential findings occurred. The role of the DNP student to uphold professionalism, remain motivated, and perform all inquisition with absent of bias has been maintained. Developments subsequent to the above are a practice-focused problem restatement and clarification, a presentation of intended sources of evidence, and an analysis and synthesis of procedures.

Practice-Focused Questions

Local Problem, Gap-in-Practice, and Practice-Focused Question

Obesity in Texas has continued to climb higher in its prevalence for decades (CDC, n.d.). Multiple interventions from a plethora of disciplines have tried and failed to slow its growth rate. There has not been a successful measure to date to have positive impact on obesity. Weight bias is present in all levels of healthcare; private, state, and national. The discriminatory behavior must be addressed; as Texas ranks in the top ten states for adult obesity, it presents an excellent beginning point (RWJF, 2017).

The gap in practice is found in the hesitation to address the problem evidential in research findings (Puhl et al., 2015). Many healthcare providers would not describe themselves as enablers of injustice or prejudice. Nevertheless, the obese are stigmatized repeatedly. Therefore, the action of the discrimination is established whether it is outright or implicit. Lacking in practice is provider self-awareness followed by absolution.

A binary approach to the practice-focused question is offered. The transformation of nursing practice can occur only with a luminous identification of the problem prior to efforts exhausted in unearthing its most optimal intervention. The following two questions are investigated: In nursing professionals, what are the perpetual antecedents associated with treating patients of obesity that are contributory to negative implicit weight bias in the provider-patient relationship? And, given the significant impact to health inequalities, what are the most effective weight bias interventions inspiratory of recognition of the bias and reduction of stigmatizing attitudes in the nursing field?

Clarification of Purpose

The dissolution of nursing provider bias in the care of the obese and overweight is the reigning component of this project. Persevering to disintegrate discrimination of the obese is the stepping stone to altering the trajectory of the obesity epidemic. The execution of a systematic review of the literature aligns with the goal of helping to progress clinical practice relevant to care of the obese and overweight. A synthesis of the literature provides the knowledge requisite of augmenting vigilance in obesity care practice techniques while conjointly undertaking an essential social justice issue. Along with the aforementioned, a systematic review has exposed future research needs apropos to the healthcare of the obese.

Clarification of Operational Definitions of Key Aspects

Weight bias operationally defined as a noun is a preconceived tendency or opinion regarding an individual of a contrasting weight category (Alberga et al, 2016; DeBarr & Pettit, 2016). Weight bias operationally defined as a verb is the action of judging, stereotyping, or discriminating against an individual of a contrasting weight category (Alberga et al., 2016; DeBarr & Pettit, 2016).

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Sources of Evidence

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Identification of Sources of Evidence

This systematic, integrative review of the research literature was not a meta-analysis or meta-synthesis since combining the evaluation of both quantitative and qualitative studies is most advantageous in the dissection of bias and its implications on the obese. Empirical and theoretical literature were both sought. Credence was given to

works of the highest level of evidence. The focus was on primary, peer-reviewed sources of evidence. The following databases were used: CINAHL Plus, Cochrane Database of Systematic Reviews, Cochrane Central Register of Controlled Trials, Joanna Briggs Institute, Medline, Military & Government Collection, Ovid Nursing Journals, ProQuest Nursing & Allied Health Source, PubMed, and the World Health Organization.

Search parameters are key to a successfully executed systematic review. Articles for inclusion met the following criteria: published no earlier than 2013, full text availability, English language, and peer-reviewed. Scholarly books as well as technical and research reports were also sought. Exclusion criteria were the contrary of the above. The following keywords were used: *weight bias, implicit weight bias, weight-bias society, weight discrimination, weight prejudice, weight sensitivity, weight stigma, provider bias, obesity, obesity knowledge, obese, obesity-associated, obesity-linked, overweight, fat phobia, cultural humility,* and *cultural competence*.

Institutional permission and ethical procedures. Protections to ensure the ethical adherence included submission to the Walden University IRB for approval of the project prior to progressing to data collection, analysis, and synthesis (IRB approval number 12-12-17-0732153). Ensured was the active enrollment in doctoral study of the doctoral candidate as author. Additionally, the doctoral candidate as author did not utilize data from a partner organization, conduct surveys or interviews, or perform any research activities without IRB ethics approval. The doctoral candidate as author further ensured no proprietary, sensitive, or confidential information was disclosed in the project document.

Relationship of Evidence to Purpose

Examination of the empirical and theoretical evidence directly related to weight

bias substantiates the current research, demonstrates the problem of weight bias exists,

and establishes the need for practice change and future research. The problem of weight

bias is underestimated and infrequently addressed (Latner et al., 2016; Wakefield & Feo,

2017). Exposing the bulk of research evidence or its limitation in the lack thereof provide

the nursing discipline with the indisputable data of the prevalence of weight bias and the

determination of its causes. With the uncovering of concrete affirmation, advancement to

provider self-recognition and constructive intervention can take place.

Collection and Analysis Procuring Addressing of Practice-Focused Questions

As discussed above, weight bias is an ugly aspect of nursing practice. It has

prevailed as the sole tolerated discriminatory behavior while all other forms of

discrimination have been scorned. The evidence supports its direct influence on the

increase in health disparities. As expected with negative bias, the discussion and

acknowledgement of being contributory to such is difficult; hence, the problem endures.

Collecting and analyzing tangible evidence of its existence and its incontestable

detriment to the obese is the impetus needed for promoting provider self-awareness and

interventional reformation of behavior.

Analysis and Synthesis

Systematic reviews must be certifiable as falling within the guidelines of being rigorous, comprehensive, unbiased, transparent, and reproducible. In efforts to maintain this standard, this author proposed to utilize the Cochrane Collaboration for the analysis and synthesis of the data. The Cochrane Collaboration offers a free handbook and an open learning library to assist in this integral piece of the systematic review.

Summary

Section 3 has provided the reader with the intended route for collection and analysis of the evidence. The practice-focused questions focused on evaluating the etiology of weight bias and identifying effective interventions for its resolution with their local and gap-in-practice relevance have been revisited. Sources of evidence are explored through display of pertinence to specifics in the investigation with regard given to project ethical protection and IRB approval, relationship to project purpose, and capacity for addressing the practice-focused questions through the collection and analysis aspect. The upcoming segment will expose the eagerly awaited findings and recommendations of the evidential analysis and synthesis.

Section 4: Findings and Recommendations

Introduction

The primary purpose of this doctoral project was to analyze the presence and implications of weight bias, a significant problem in healthcare; the overall aim was to improve the quality of nursing care given to the obese. A secondary purpose was to learn how to intervene to eliminate the social injustices that have been ignored. Locally, the prevalence rate of obesity in Texas has increased more than 10% in adults since 2000 (RWJF, 2017). Weight bias is detrimental to the care of the obese; it has been shown to increase depression and reduce participation in preventive healthcare (Fruh et al., 2016). The prejudice against the obese is often disregarded in the public sphere and in healthcare. Examining its antecedents and ascertaining interventions to reduce discrimination, whether implicit or explicit, is called for: Obesity continues to rise in epidemic proportions. These measures are proposed to lessen the gap in practice. Weight bias has been discovered among healthcare professionals across all disciplines. Yet, a sparse amount of research has been carried out on providers' self-awareness of weight bias and its ramifications on the psychosocial needs of the obese.

To address this problem and lessen its effects on the overweight and obese, the nursing practice-focused questions in this systematic review were as follows:

1. In nursing professionals, what are the perpetual antecedents associated with treating patients of obesity that are contributory to negative implicit weight bias in the provider-patient relationship?

2. Given the significant impact to health inequalities, what are the most effective weight bias interventions inspiratory of recognition of the bias and reduction of stigmatizing attitudes in the nursing field?

The sources of evidence used in this study were identified in Section 3 along with an explicit search strategy that listed both inclusion and exclusion criteria for the literature review. The evidence was obtained through multiple electronic databases. Data were extracted and ranked in both narrative and tabular display (Appendix A) in a methodological tactic that reflects the study's strength and validity. The levels of evidence pyramid for evidence-based practice was used to validate the quality of studies (Appendix B; Walden University [WU], 2006). It was decided to apply the Newcastle-Ottawa Scale (NOS; a tool recommended for bias assessment by the Cochrane Collaboration [Lo et al., 2014]) to the critical appraisal of bias (*study* bias not weight bias) in study outcomes and selection of the studies most suitable for this research (Appendix C; Lo, Mertz, & Loeb, 2014).

Findings and Implications

Literature Search Analysis and Synthesis

The search of scholarly articles yielded 102 peer-reviewed works that met the inclusion criteria. After critique and review, I identified 26 sources for analysis. The sources selected offer a vast representation of study approaches to the investigation of weight bias in the ambition of myself to embolden the comparative aspect of the analysis as well as the transferability of outcome recommendations established (Grove et al., 2013). Keeping in alignment with the composition of a systematic review, both

quantitative and qualitative studies are displayed with experimental and descriptive

design tactics. A rationally planned review commences here with its organization

according to methodology subsets beginning with those at the peak of hierarchy in level

of evidence quality (WU, 2006). Taken into consideration is the understanding of the

amount of available literature at higher levels slight in comparison to that found as one

progresses down the pyramid. Moreover, experimental designs of research with weight

bias are limited due to ethical considerations. In addition, restricting the review to

analysis of studies specific to the nursing discipline may infer bias of bias, a tunnel-vision

of the existence of weight bias experienced across healthcare, and a disservice to those

nurses who may design weight bias interventions. Presenting the scientific knowledge

supportive of an inevitable need for professional collaboration to strengthen impact to

this social injustice issue is integral. Consequently, this review is dominant of nursing

influence on weight bias while reverential to additional health disciplines whom nurses

must work together with in patient care endeavors. In restatement, the designs of the

studies can be observed relevant to their placement below in addition to inclusion in a

synopsis of quality and findings presented congruent with Cochrane directives (Appendix

A).

Systematic review and meta-analysis. In a systematic review conducted in

Canada including a myriad of perspectives due to incorporation of primary sources as

well as gray literature, significant gaps in knowledge of the impact of weight bias on the

obese imposed by healthcare professionals was identified (Murphy & Gardner, 2016). In

addition, obesity stigma was found prevailing among healthcare professionals with its

likelihood for contribution to poorer mental and physical health conjectured (Murphy & Gardner, 2016). Although the inclusion criteria in this SR did allow for study of healthcare professionals, its emphasis was on pharmacists and pharmacy students; it was concluded that both implicit and explicit weight bias are present in this population and further research is needed (Murphy & Gardner, 2016). In a meta-analysis examining optimal interventions for weight bias, multiple measures of weight bias were used to ascertain the level of its presentation across several domains; the Attitudes Toward Obese Persons (ATOP) and Beliefs About Obese Persons (BAOP) scales were most prevalent (Lee, Ata, & Brannick, 2014). Additionally, the Fat Phobia Scale (FPS), the Antifat Attitudes Questionnaire (AFA), the Antifat Attitudes Test (AFT), the Obese Persons Traits Survey (OPTS), and the Universal Measure of Bias-Fat (UMBF) were explored (Lee et al., 2014). The paradigms for interventions researched were controllability through lecture to reduce obesity blame, empathy through listening to the lived experiences of the obese, and social consensus through laboratory repeated measure studies using social favorable feedback tactics (Lee et al., 2014). Findings displayed a small, positive impact on weight bias with each methodology and a need for additional research on interventions for weight bias due to its detrimental effects on the obese (Lee et al., 2014).

Prospective cohort study. In Europe, 1795 medical students were analyzed at Year 1 of medical school and again, at the culmination of year four for presence of weight bias (Phelan et al., 2015). The data obtained and appraised from the medical students was compared with that of the general public within the same time period

(Phelan et al., 2015). The aim of this study was congruent with unearthing possible antecedents of weight bias. In students of medicine who had less contact with obese patients, bias of both implicit and explicit projection increased over the four years; however, implicit weight bias decreased when averaging the totality of surveyed medical students (Phelan et al., 2015). Contrarily, as the general public's level of explicit weight bias remained essentially without change in this timeframe, the medical students' explicit weight bias displayed an intensification (Phelan et al., 2015). Phelan et al. (2015) concluded reduction in weight bias may begin with promotion of greater interaction between obese patients and medical students as well as bringing to the forefront and eliminating unprofessional behavior in weight bias role modeling of faculty.

Cross-sectional study. Gudzune, Bennett, Cooper, & Bleich (2014) performed a cross-sectional study of the influence of weight bias experienced by the overweight and obese from primary care providers (PCP). Over 600 adult primary care patients with excess weight were surveyed over a 12-month period; the ramifications of receiving weight stigma from their PCPs was scrutinized (Gudzune et al., 2014). More than 20% of the study participants conveyed weight bias; those who acknowledged implicit bias were less likely to lose weight when compared with those who did not receive weight bias from their PCPs and in which weight was discussed (Gudzune et al., 2014). Gudzune et al. (2014) concluded greater success is found in reducing overweight and obesity in patients who are not recipients of implicit bias.

Repeated measures pretest-posttest study. An innovative technique to evaluate empathy modification of healthcare professionals who participate regularly in the care of

the obese was performed in a qualitative approach in New Zealand (Hales, Gray, Russell,

& MacDonald, 2018). Qualitative studies are more commonly nonexperimental in nature;

nevertheless, the intent of this study was to investigate the capacity to change the learned

stigmatizing behavior of healthcare professionals pertinent to obese persons (Hales et al.,

2018). Nurses composed 85% of the participants in this study; obtaining audiotaped

interviews assessing weight bias pre- and post-intervention was the data collection

strategy (Hales et al., 2018). Study participants wore obesity simulation suits for two-

hour periods and were instructed to engage in a public activity (Hales et al., 2018). Post-

intervention, negative judging of the obese was reduced; might the rehearsal of obesity be

the interventional key to producing the dissolve of weight bias (Hales et al., 2018)?

Ex post facto retrospective studies. Ex post facto research attempts to

demonstrate a causal relationship with an independent variable that is not amenable to

researcher manipulation (Grove et al., 2013). Extracting data from a longitudinal study on

ageing, Jackson, Beeken, & Wardle (2014) studied the consequences of weight bias (as

the independent variable) through biophysical measures. Weight and waist circumference

of study participants were obtained at inception of study with weight discrimination

affirmed in the preceding 12 to 24 months (Jackson et al., 2014). Following the reporting

of weight bias, biophysical measures were then repeated within the next 12 to 24-month

timespan (Jackson et al., 2014). Statistical analysis observed increases in weight by an

average of 3.7 pounds and waist circumference by an average of 0.4 inches in the

participants who experienced the stigmatizing behavior between objective collection of

weights and waist circumferences (Jackson et al., 2014). Conclusions made were support

of the negative impact of weight discrimination being the promotion of obesity and weight gain (Jackson et al., 2014).

In an additional study of similar design, the primary focus was on an investigation of weight with patient satisfaction with provider communication as independent variable (IV). A secondary investigation of race/ethnicity in regards to patient satisfaction took place as well (Wong, Gudzune, & Bleich, 2015). Researchers here scrutinized 2009-2010 data collected by the Agency for Healthcare Research and Quality (AHRQ) with attention to the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey (Wong et al., 2015). It was found that white obese patients reported similar communication contentment as white normal weight patients; contrarily, black obese patients reported a significant decrease in effective provider communication or time spent with patient (Wong et al., 2015). Blacks have a higher prevalence of obesity than whites with a greater amount of co-morbid diabetes and hypertension (Wong et al., 2015). These findings display weight bias existence being associated with race (Wong et al., 2015). Thirdly, Richard, Ferguson, Lara, Leonard, & Younis (2014) retrospectively dissected data from a large sampling study of 6,628 persons from the Medical Expenditure Panel Survey (MEPS) and the CAHPS survey resulting in an outcome supportive of Wong et al. (2015). Richard et al. (2014) used multivariate models to analyze the findings from MEPS and CAHPS relevant to obese patients. Outcomes in Richard et al. (2014) observed a reduced score of 0.19 points in effective provider communication where obese persons where patients, lesser odds of display of provider respect for the opinions of obese patients, active listening of the obese, and spending adequate appointment time

with the obese. Characteristics here were summarized into obesity as being negatively associated with appropriate provider communication efforts (Richard et al., 2014). Richard et al. (2014) recommends diversity and sensitivity training to active providers and students; moreover, policy makers are requested to become more involved with nationwide practices for eliminating obesity antipathy beginning with suggestion for PCPs to receive increased Medicaid payments for obesity care as they must coordinate a team approach for these patients.

Weight bias from healthcare providers is linked to reduced rates of preventive care and increased emergency room visits among the obese (Tomiyama et al., 2015). Such is the inspiration for a retrospective ex post facto study of obesity specialists performed by Tomiyama et al. (2015). Using the IAT, the researchers gathered data regarding implicit and explicit weight bias from participants specializing in obesity healthcare attending ObesityWeek in 2013 (Tomiyama et al., 2015). These data were then compared to similar data obtained from obesity specialists in attendance at the annual meeting of the now Obesity Society in 2001 by Schwartz, Chambliss, Brownell, Blair, & Billington (2003). Implicit weight bias attitudes showed a reduction in presentation between 2001 and 2013. However, explicit weight bias increased in this timeframe (Tomiyama et al., 2015). Obesity specialists reported greater negative feelings toward the obese with characterizations of significantly more laziness, stupidity, and worthlessness than thin people described (Tomiyama et al., 2015). Those who reported more positive, professional experiences with obese patients displayed lower levels of weight bias (Tomiyama et al., 2015). Noted is although the survey results cannot be exclusively

compared, the participants in 2013 remain from as near as possible to an analogous sampling with that of 2001. The researchers hypothesized distinguishing obesity as a disease by the American Medical Association during this period may have resulted in the decrease in implicit bias; contrarily, the upsurge in explicit bias warrants further research into abating management of obesity focusing on weight loss with transition to its focus being health optimizing (similar to the previously mentioned HAES model) (Tomiyama et al., 2015).Unfortunately, even obesity specialists are not immune to weight bias as confirmed in repeated measures testing here.

Case study. In Australia, research of weight bias in healthcare providers in 2006 exhibited bias to occur in 69% of interactions with physicians, 46% of interactions with nurses, and 37% of interactions with dietitians (Wakefield & Feo, 2017). In a case study of the impact of weight bias on the obese, fear and shame conveyed to the participant when seeking obesity medicine care catapulted her to gain an additional 66+ pounds (Wakefield & Feo, 2017). This participant reported weight discrimination and judgment by not only a bariatric surgeon but the emergency department staff when seen for abdominal pain (Wakefield & Feo, 2017). The study concluded the shaming approach to motivating obese individuals to lose weight results in a divergent physical outcome as well as harm to the psychosocial well-being of the patient; the researchers recommend motivational interviewing with respectful relationship building to be chief to altering the obesity illness (Wakefield & Feo, 2017).

Survey and questionnaire studies. As obesity and bias is more feasible to examine in observational study, research in weight discrimination is most available in

frameworks of inquiry. Noted, weight bias research remains minimal and requisite of further works; nonetheless, the accessible dominance at present is that of surveys and questionnaires (Puhl et al., 2015). Hence, presented here is a composition of all inquiry-research meeting the pre-determined inclusion criteria for this SR.

In a survey of 81 adult females of obesity, weight bias internalization, discrimination, and physical and mental health statuses were assessed (Latner, Barile, Durso, & O'Brien, 2014). Participants were recruited from social media; the Weight Bias Internalization Scale (WBIS), the Everyday Discrimination Scale (EDS), and the Medical Outcomes Survey Short-form Health Survey (SF-36) were applied and statistically analyzed (Latner et al., 2014). A significant association between weight bias and physical health-related QoL measures was shown; this significance was not demonstrated with mental health-related QoL measures, though, it was strongly associated with them (Latner et al., 2014). Latner et al. (2014) found clinical implications recommended as the assessment of weight and not simply the treatment; Health at Every Size (HAES) interventions are advised as the potential methodology for reducing weight through focus on its co-illnesses rather than the weight itself. Such theory allows for self-confidence and self-acceptance whereby improving participation in weight reduction efforts. In an online questionnaire study assessing weight stigma, 81% of the 634 overweight participants reported being the recipients of weight discrimination (O'Brien et al., 2016). In alignment with prior weight bias research, this study found association between weight stigma and greater emotional eating, loss-of-control eating, and psychological distress (O'Brien et al., 2016). Researchers here advise further longitudinal studies to clarify the

relationship of weight bias and disordered eating behaviors and improved awareness of weight stigma in policy makers in aim of developing anti-weight bias policies in medical, work, and school environments (O'Brien et al., 2016).

Canada is on a mission. In a qualitative interview study, Bombak, McPhail, & Ward (2016) delve into the obese as a target population for discrimination. 24 women of excess weight submitted to semi-structured, qualitative interviewing in two major Canadian cities; for illustration, qualitative interviewing is a process founded to unearth the understanding of another's lived experiences (Bombak et al., 2016; Grove et al., 2013). Oppression of the obese patients was conveyed repeatedly; explicit incidences of name calling, communicating disgust, and inadequate care by various health providers were described (Bombak et al., 2016). Specifically, a physician stated "you're going to be a menace to the government," in regards to necessity to lose weight (Bombak et al., 2016, p. 98). Refusal to provide services were also experienced by the participants; an obese patient verbalized having her IUD in place for six years (one year past recommended timeframe) due to inability to locate a provider who would perform an exam and removal (Bombak et al., 2016). Consensus of the interviews showed providers to consistently perceive the obese as lazy and noncompliant (Bombak et al., 2016). Reported in this study is the stance of the American College of Obstetrics and Gynecologists (ACOG) 2014 advisement as nurse practitioners are to "avoid stigmatizing their obese patients," (Bombak et al., 2016, p. 96). Canada has formed an entity specific for the advocation of the obese, the Canadian Obesity Network (CON) (Bombak et al., 2016). The CON is

committed to anti-discrimination prevention and awareness through active involvement of health professionals and other obesity stakeholders (Bombak et al., 2016).

An innovative surveying of nursing and psychology students specific to implicit weight bias was performed by Waller, Lampman, & Lupfer-Johnson (2012). Noted is the collection and analysis of the evidence for this SR occurred prior to this narrative; at such time, this study remained within the five-year realm for inclusion. It is decided not to exclude this study as it is specific to nurses and offers an advanced approach to measuring bias. Ninety study participants submitted to an Implicit Association Test (IAT) in a time restricted dimension; the IAT was selected as the researchers indicate prior bias data concerning nursing has predominantly been collected through self-report tactics (Waller et al., 2012). The IAT has the capacity to reduce social desirability response set bias found to be at high risk with self-report data collection (Grove et al., 2013; Waller et al., 2012). Interesting to highlight, the IAT has also proven its reliability in the assessment of various forms of prejudice such as race, ethnicity, and gender (Waller et al., 2012). Photographic stimuli were combined with positive and negative attributes selected from previous study in weight bias; participants were requested to provide an impromptu response when the images were displayed (Waller et al., 2012). Such testing methodology portrays appropriateness, reliability, and validity and vigilance in analysis for congruency in image pairing (Waller et al., 2012). As my intention has been to uncover antecedents of weight bias, the findings here may be helpful in the connotations observed in the IAT due to unprepared retorts. Nevertheless, outcomes of Waller et al. (2012) demonstrated implicit weight bias in the participants across the board and stronger

bias towards females with excess weight. Per the researchers, weight bias affects all areas of one's life; further research is needed to stimulate personal awareness of weight bias in health professionals in order to rectify its unwanted presence (Waller et al., 2012).

Garcia, Amankwah, & Hernandez (2016) employed the Nurses' Attitudes toward Obesity and Obese Patients Scale (NATOOPS) to assess weight bias in nurses and support staff caring for pediatric patients of obesity in an online survey study of 308 participants. In this sample, 86% of the participants were RNs; with a statistical analysis using logistic regression, it was found that both the RNs and the support staff displayed weight bias attitudes and behaviors (Garcia et al., 2016). Nurses working in higher acuity areas were found to have greater negative stereotyping beliefs of the obese with increased victim blaming due to opinions of obesity being solely a choice (Garcia et al., 2016). The researchers recommended bariatric sensitivity training and further research in weight bias that directly involves nurses to untangle the etiology of the bias in the nursing field (Garcia et al., 2016).

In Thailand, we again witness the use of the ATOP scale, the F-scale, and the BAOP scale in a questionnaire study of weight bias among healthcare professionals (Ratanpichayachai, Paothong, Phattharayuttawat, & Pramyothin, 2017). Physicians in training, nurses, and staff support members comprised the 311 participants; resulted was a dominance of bias towards obese persons from physicians in training when compared to nurses and support staff (Ratanpichayachai et al., 2017). Additionally, men were observed to have greater negative attitudes than women per scores on the F-scale (Ratanpichayachai et al., 2017). These researchers concluded a recommendation of

weight bias interventions to be designed for male providers, most specifically those training to become physicians (Ratanpichayachai et al., 2017).

Healthcare professionals who treat eating disorders are also vulnerable to weight bias. In an online survey of anonymity, participants who specialize in the provision of care of those with eating disorders were studied for degree of weight bias and beliefs regarding managing the obese patient (Puhl, Latner, King, & Luedicke, 2014). Sample size in this study was a total of 369 healthcare professionals and practitioners who responded to queries including the ATOP scale, the F-scale, and the Universal Measure of Bias-Fat (UMB-FAT) scale with Likert scale measures incorporated (Puhl et al., 2014). Additionally, researchers designed and included a measure of colleague perception of weight bias among practitioners (Puhl et al., 2014). Weight bias was found present among the participants; also, it was positively associated with belief of cause of obesity to be behavioral rather than environmental or genetic (Puhl et al., 2014). 56% of participants acknowledged witnessing weight bias comments made by colleagues while 42% conveyed their colleagues to have negative stereotyping regarding the treatment of obese persons (Puhl et al., 2014). 35% of practitioners admitted to felling uncomfortable caring for obese patients (Puhl et al., 2014). The researchers recommend further research into weight bias and its effects on therapeutic relationships between practitioners treating eating disorders in the obese (Puhl et al., 2014).

Surveying 4,732 global students of medicine in their first year of study was performed as the basis for a future longitudinal study by Phelan et al. (2014). The sample will again be surveyed in their final year of study in medicine; these measures are not yet

completed, therefore, the data accessible at present is a survey design. Per Phelan et al. (2014), healthcare providers show less respect for obese patients with stereotypical behaviors observed including explicitly quantifying the obese to be lazy, unmotivated, noncompliant, and unhealthy. Insufficient studies exist that examine the impact of provider bias on the obese. Noted, physicians assigned to read vignettes from obese patients articulated a reduced amount of interest in helping the obese and the activity noted to be a waste of their time (Phelan et al., 2014). The researchers identified physicians to be notorious for less time spent with the obese and lack of commitment to interpersonal relationship building (Phelan et al., 2014). Thus, the query arises as to the antecedents for weight bias being medical training or its presence prior. In the students surveyed in year one, 74% showed implicit weight bias and 67% demonstrated explicit bias (Phelan et al., 2014). Characteristics found were lower BMI in study participants to be positively associated with greater bias both implicit and explicit as well as overall disdain with the obese (Phelan et al., 2014). Males exhibited more overall bias than females, Whites and Hispanics displayed greater implicit bias with younger age observed to have higher rates of explicit bias (Phelan et al., 2014). Blacks had the most positive implicit and explicit weight bias attitudes (Phelan et al., 2014). Removing race as a factor, the greatest predictor of implicit bias was being US-born; this raises the conjecture of a US culture of personal blame being prevalent in weight bias (Phelan et al., 2014).

With weight bias being established as a problem, Puhl, Luedicke, & Grilo (2014) led a study efforted to assess weight bias among healthcare students in aim of identifying future interventions where needed. A sample of 107 participants actively enrolled in post-

graduate health disciplines completed questionnaires of anonymity on obesity stigma and then attended a lecture on its clinical implications (Puhl et al., 2014). The UMB-FAT scale was incorporated; descriptive results showed 3% of participants reported derogatory humor about obese patients as acceptable behavior (Puhl et al., 2014). 50% of participants in this study conveyed their colleagues to hold negative attitudes about the obese populace and 65% of study participants reported being direct witness to explicit bias from healthcare providers (Puhl et al., 2014). I reiterate, these are post-graduate healthcare students. The researchers concluded the findings to support the necessity of obesity-stigma reduction training in health-related professions at all levels with attention to obesity not causal from behavioral factors alone (Puhl et al., 2014).

Two survey studies meeting the pre-determined inclusion criteria were found to have absence of discriminatory actions or beliefs concerning weight bias towards the obese patient population. Thought-provoking to note, both studies were exclusive of nursing as the target discipline of assessment. In the community healthcare setting in China, 297 nurses partook in a questionnaire tactic of study incorporating the ATOP scale, the External Weight Loss of Control Subscale (WLOC) derived from the Dieting Belief Scale, and a profile of demographics (Wang, Ding, Song, Zhu, & Wang, 2016). Researchers here postulate obese persons as being health impaired due to negative attitudes from health professionals harboring continuing care efforts (Wang et al., 2016). The Chinese nurses scored relatively high on the ATOP scale. This indicates neutral or positive attitudes toward the obese (Wang et al., 2016). Furthermore, the average ATOP score was higher here when compared with American nurses and medical students;

WOLC scores were also positively correlated with Chinese nurses' ATOP scores (Wang et al., 2016). It was found that Chinese nurses were more likely to believe obesity to be beyond the control of the person which we have not observed in studies of American participants to date (Wang et al., 2016). In addition, Chinese culture differs from that of the US as Confucius encourages humility and politeness to others resulting in the Chinese less likely to express dissatisfaction to others (Wang et al., 2016). Again, we can observe believed disease etiology and possibly culture to impact weight bias.

In an experimental survey design using vignettes, 92 students of nursing in the United Kingdom were studied for negativity of attitude in treating the obese population (Nicholls, Pilsbury, Blake, & Devonport, 2015). Participants were given one of four vignettes depicting a patient story with three containing obese patients of differing causes of disease and one being a normal weight patient; after reading through the presentation, the student nurses completed a questionnaire identifying how they would proceed with healthcare advisement (Nicholls et al., 2015). Findings displayed the UK student nurses to make decisions without regard to obesity cause or pre-conceived judgment; these study participants did not exhibit weight bias nor social desirability bias; they did show professional choices made with empathy and compassion irrespective of patient size in accordance with the Nursing and Midwifery Council standards (Nicholls et al., 2015). It appears that when responsibility for excess weight was not considered its etiology, bias did not occur. The researchers concurred nursing curriculums inclusive of addressing and inspiring positive attitudes toward persons of obesity is an effective prevention method of biased nursing care (Nicholls et al., 2015).

Articles. In Fruh et al. (2016), the awareness of healthcare provider weight bias

and proposals to effectuate greater compassion for the obese is reviewed at length. Noted

is an increase in weight discrimination in America of 66% in the last ten years (Fruh et

al., 2016). Fruh et al. (2016) shares a survey study finding of nurse practitioners (NP) at a

conference in 2016 for obesity to report negative beliefs and attitudes toward patients of

excess weight expressed by the NP attendees. Moreover, published in the Journal of

Advanced Nursing in 2007 was a study of 250 physicians shared again by Fruh et al.

(2016). 40% of the physicians in this study reported negative reactivity toward obese

patients with a low likelihood of recommending weight loss medications or bariatric

management   (Fruh et al., 2016). Alarming, 50% of primary care physicians identified

obese patients as "awkward, unattractive, ugly, and non-compliant" with less time spent

with their obese patients in comparison to their normal weight patients (Fruh et al., 2016,

p.427). In a survey study of obese women needing gynecological care, 52% conveyed

weight bias hindering their health care; delayed treatment was identified due specifically

to negative attitudes from providers, discourteous treatment, and uninvited weight loss

advice (Fruh et al., 2016). The authors provide many recommendations for altering

weight bias; people-first language is discussed with attention to abating identifying

patients by their disease (Fruh et al., 2016). Moreover, the authors indorse NPs as an

entity to improve national health through overcoming personal obesity bias and making

obesity bias a public health priority (Fruh et al., 2016).

In 2015, the Canadian Weight Bias Summit was held. Alberga et al. (2016) offers

a presentation of the Summit findings; the goal here is identified as the encouragement of

collaboration across the disciplines as well as internationally for actions to reduce weight bias. The Summit conveyed weight bias to have significant association with detrimental physical and psychological consequences to the obese inclusive of depression, anxiety, disordered eating, lower self-esteem, avoidance of physical activity and preventive healthcare, and increased mortality risk (Alberga et al., 2016). Weight bias is shown to be prevalent in all aspects of life with health professionals not resistant to taking part in the discriminatory behaviors (Alberga et al., 2016). This Summit summarized three foci for optimal interventional activities: person-first language as potential consensus across disciplines, incorporating persons of obesity into all factors of weight bias research, and bringing about weight bias collaboration from healthcare, education, and public policy makers (Alberga et al., 2016). Concluded was the need for more robust research to reduce weight stigma performed by global partnerships between researchers, practitioners, and policy makers (Alberga et al., 2016).

Giese (2016) highlights the opportune moments provided to nurse practitioners in obesity care. Noted is the well-documented bias and stigmatization of obese persons by healthcare providers; the concentration in this article is to inspire change in NPs begins with self-reflection (Giese, 2016). Giese calls for greater compassion through use of the Model for Structured Reflection (MSR) specific to the managing of obese patients; five phases leading to insight gleaned are incorporated (Giese, 2016). Accepting the existence of bias is inevitable for Giese (2016); tackling it with empathetic care from NPs consistent with the Code of Ethics per the America Nurses Association is not only a duty of the professional nurse, but a privilege that starts with self-assessment. Nutter et al.

(2016) examines weight bias in their article depicting the differentiation between the concepts of weight-centric, health-centric, and health at every size methodologies. Regardless of varying conceptualizations, Nutter et al. (2016) finds weight bias linked to the belief of excess weight being the sole responsibility of the individual. Giving limelight to weight bias as a social justice issue imperative of greater recognition to produce social equity is principal to these authors (Nutter et al., 2016). Nazione (2015) addresses cultural humility as integral to the improvement of provider weight bias in her article inspiratory of this SR. Expressed is culture having the potential to define the presence or absence of bias; aiming for cultural competence is displayed as being a stimulus for stereotyping (Nazione, 2015). For Nazione (2015), providers trained in cultural sensitivity require strong clarification in actions of humility as opposed to actions fueling power imbalances when believing one is competent in another's culture. Moreover, weight bias is not anticipated to lessen absent of provider capacity for openness, receptivity, and modesty acquired in cultural humility training (Nazione, 2015). Likewise, increasing positive interactions between students of healthcare disciplines and integrating testimonials from the obese into training in medicine and nursing are constituents for overcoming weight bias in health settings per concluded counsel of Nazione (2015).

With the above presentation of 26 studies into weight bias representing all levels of the evidence pyramid with the sole exception of randomized controlled trials, a comprehensive and unbiased summary of the research is rendered (WU, 2017). All studies meeting the predetermined inclusion criteria have been critically analyzed with

their discourse given; there is no degree of selective inclusion supportive of this author's beliefs or outlooks. In addition to a logical arrangement of studies per ranking on the levels of evidence pyramid in this narrative, each study has also been evaluated, where applicable, by the components of the NOS. The nonrandomized studies have each met the threshold of the NOS determined here to be no less than 6 points for this SR; this calculation ensures higher quality and greater validity of study findings (Lo et al., 2014). Through the undertaking of these measures, this SR is both transparent and reproducible.

Among the 26 selected studies, 2 are at the highest level of the evidence pyramid as a systematic review and a meta-analysis, 1 cross-sectional study, 1 pretest-posttest experimental study, 1 prospective cohort study, 4 retrospective ex post facto studies, 1 case study, 11 survey studies, and 5 articles of study. Characteristics observed were the prevalence of weight bias consistent in nursing and other healthcare disciplines in 92% of the literature the negative impact on quality of care when either implicit or explicit bias occurs, lack of immunity to weight bias regardless of specialty, the hindrance of participation in preventive medicine of the obese who have experienced bias by healthcare providers, and a contrary effect to weight management when bias takes place. Consensus on possible antecedents include US culture of blame, an assumption of the etiology of obesity as a personal choice irrespective to environment or genetics, a belief in the obese as lazy, unmotivated, unintelligent, and noncompliant, and the widespread societal mindset of weight shaming as an acceptable form of stigmatizing. Of the 26 studies, 2 displayed absence of weight bias when treating the obese; essentially, these surveys were performed outside of the US and were specific to nursing (China and the

UK precisely). This equates to less than an 8% likelihood of obese patients in *not* experiencing bias when seeking healthcare services.

Unanticipated Limitations or Outcomes

Not expected to be observed in study outcomes were less time spent with obese patients by healthcare providers, racial background having an effect on weight discrimination, and explicit negative terms describing the obese still in use and believed acceptable to some. HAES was not anticipated; nonetheless, the concept showed strong meaning and usability. Limitations are using convenience sampling as this limits generalizability, lack of randomization in study groups, using self-report in the survey studies as response bias may occur, lack of causality with one-time data collection designs, and unknown volume of ethnic diversity.

Implications

This systematic review has fortified the acknowledgment of weight bias in nursing and other healthcare disciplines as a national problem not only worthy of resolution but desperate for such due to its harms to society. I have presented a thorough, unbiased critique of the last socially acceptable form of bias in the healthcare setting and in the public realm. For the obese individual, we have seen numerous accounts of the injurious impact of weight bias on physical and psychological health whether implicit or explicit. In communities, obesity occurrence continues to rise in the US and globally. As an epidemic with no signs of slowing, discriminatory treatment of those with the disease observed here has counterintuitive results; therefore, without the elimination of weight stigmatizing, the disease of obesity will likely continue to wreak havoc on our

communities. Institutions and healthcare systems are burdened with the management of the chronic illness of obesity. Obesity is a financial nightmare to hospitals, schools, nursing homes, prisons, the military, the police and fire, and more. Negative bias of those suffering with the disease increases both incidence and prevalence rates fueling a cyclic national problem that has become devastating; not one person has discovered long-term success in the fight against obesity. Weight bias, unequivocally researched here, may be the underpinning of obesity.

Positive Social Change

As prior, discriminatory actions are societal injustices. Shaming, judging, and being spoken to with a condescending or all-knowing tone are only three examples of weight bias the obese may experience on a daily basis. As nurses, we are ethically responsible to advocate for the worth of every individual regardless of attributes (Grace, 2014). As Walden University doctoral candidates, promotion of social justice is a directive each student accepts upon program admission (WU, 2017). Reducing or eliminating an action, whether implicit or explicit, that is unkind to the psychosocial well-being and subsequently the physical health of others is a sincere and incontestable endeavor for positive social change.

<div align="center">

Recommendations

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Established is the magnitude of the problem of weight bias. The gap-in-practice exists in willingness to self-identify, disclose, and rectify the actions in a manner that does not allow for repeat of the behavior. As nurses, we are human. As humans, we are not perfect. Striving to better ourselves in aim of the betterment of others is the essence

of our nursing doctrine and what makes nurses exceptional; we must continue to find the optimal methodology to treat the individual not simply the condition. Obesity is a condition; treating obesity has not proven successful. Treating *the individual* with obesity may alter the course of the disease. Where do we begin?

Correction of Education Efforts

To eradicate weight bias, nursing professionals can step forward to be the spokesmodels of anti-discrimination in healthcare as well as activists for passing on these actions to our next generation of providers. As observed in the literature, the presence of bias is not questionable; however, it is both explicit and implicit. Therefore, many providers are not attuned to the implications of their actions or lack of when caring for the obese population neither have they reflected on their own feelings regarding persons of excess weight. In a multifarious society, the approach to caring for any human being of difference, whether race, religion, sex, age, socioeconomic status, ethnicity, size, etc., requires sound cultural humility training. Culture must be clarified as *any* divergence from self, not simply race or ethnicity (Foronda et al., 2016). Although intended to produce positive results, cultural competency training is backfiring (Hook, Davis, Owen, Worthington, & Utsey, 2013; Foronda et al., 2016; Nazione, 2015; Yeager & Bauer-Wu, 2013). The solution to negative bias commences with our profession accepting this inadvertent mistake in educating others to believe they can become all-knowing in another's culture as such focus has undermined our ability to listen to others without pre-conceived philosophies (Foronda et al., 2016). Aiming for cultural competence creates a sense of ego and power imbalance in healthcare relationships (Hook et al., 2013; Foronda

et al., 2016). Nurses must be the first to exemplify openness to *all* persons, as opposed to superiority, for we are never competent in a culture in which we have not lived (Dreher, Lehman, & Skemp, 2016; Hook et al., 2013). Learning to think like others but understanding you will never know all there is to know about them is the essence of a humble spirit necessary for trusting partnerships with patients. Present nursing curriculum is amiss (Isaacson, 2014). Nursing instruction must alter its objective when teaching cultural awareness. Accordingly, nursing students at every level need cultural humility and sensitivity education in place of competence coaching (Isaacson, 2014). Onboarding of new nursing staff as well as annual cultural humility exercises for all nurses is a foundation for abolishing bias that we must begin building. Once appropriate comprehension of humility is gleaned, explicit bias will resolve.

The amendment of cultural nursing education is clear. Without such, efforts to nullify weight bias in the workplace will be unsuccessful. More research is warranted to create and launch a national cultural humility training directive for nurses of all educational and experience levels. By the same token, the process for social justice of the obese must carry on through the identifying and absolving of implicit bias. This DNP project culminates with 5 interventional recommendations, supplemental to the above curriculum change.

Interventions

Self-assessment. Establishing a campaign for freedom from implicit weight bias for the obese population begins with self-awareness of the healthcare provider. As displayed productive in the literature, the Implicit Association Test (IAT) is a

psychological introspection into unrevealed feelings and attitudes designed in varieties of

subject matter. Testing of underlying thoughts towards weight reveals tendency for

biased exchanges with the obese (Appendix E) (Ratanapichayachai et al., 2017). In

addition, the Beliefs about Obese Persons (BAOP) scale is a brief, 8-question test that

uses the Likert scale to ascertain the comprehension level of the disease cause (Appendix

F) (Allison, Basile, & Yuker, 1991). Nursing staff assessment of implicit response to

obese persons as well as knowledge of obesity causation through use of the IAT and

BAOP scales prior to designing staff development action items are the beginning. Both of

these scales are optimal for promptly unearthing the behaviors and opinions of nurses

pertinent to the provision of healthcare to the obese as they each are specific and time-

efficient. Distribution of the binary testing is managed best through email to the

occupational addresses of the professional nurses with anonymity of return responses to

ensure absence of social desirability bias. Nurse educators are to amalgamate the data

prior to staff development sessions and proceed with interventional options as selected

below.

It is noted, the literature review observed a preponderance of the research to have

strong association between weight bias and perceived etiology. In the US, weight

shaming was displayed as socially acceptable to some relevant to obesity being a disease

believed to be caused solely by personal choice (Bombak et al., 2016; Garcia et al., 2016;

Wakefield & Feo, 2017). Hence, in congruence with the SR findings, the IAT will

provide nurse educators with the grading of implicit bias in the nursing staff as a

collective while the BAOP will unearth the degree of obesity causation education to be

dispersed in a team-centric atmosphere. Repeating these tests annually is necessary to account for changes in staff, comparison statistics for absolution, and perpetuating a no tolerance policy of weight bias.

Obesity causation education, as above, is essential. Removing the responsibility for the disease from the individual removes blame. Ensuring evidence-based scientific causality is relayed and reiterated will enhance understanding, acceptance, and positive communication. I am recommending this to begin with integrating the obesity care strategies for health professionals and tactics for self-reflection from The Obesity Society into staff development meetings (Appendix G) (Fruh et al., 2016). Using this advisement will optimize care of the obese patient as well as inspire positive obesity subject matter to staff for team discussion.

Lived experiences. In a progressive methodology of enduring support and education, an innovative, uplifting approach to halt implicit weight bias in alignment with the literature is submitting the nursing staff to direct witness of an account of counter-stereotypical traits of an obese person. We learned of HAES (Health at Every Size) in the critique of the research. HAES focuses not on the numerical value on the scale but on the overall health and well-being of the individual irrespective of size (Latner et al., 2014). It is indisputable that the disease of obesity is associated with health risks; however, obese persons are stereotyped to have behaviors of inactivity and demotivation per the literature. Having an obese person whom is representative of self-confidence, living an active lifestyle, and lack of co-morbid conditions be a guest speaker at a staff meeting or seminar is suggested by myself. Altering the mindset of healthcare professionals as

nurses can be challenging; incorporating a visual display of HAES might be profound for some.

In ambition to cultivate and breed empathy, being privy to the lived experiences of the obese specific to weight bias in healthcare is an interventional tactic I concur with the literature on and duly recommend. Therefore, incorporation of vignettes of obese patients read aloud by nurses at staff development sessions is advised. Vignettes offer anonymity to the obese while still sharing the victimizing experiences of discrimination and their impact on health with those listening (Grove et al., 2013; Nicholls et al., 2015). Vignettes incorporated in a study of attitudes towards caring for obese patients among student nurses in the United Kingdom generated an outcome absent of negative bias (Nicholls et al., 2015). As vignettes are thought-provoking and quite powerful, I recommend instilling an anticipated behavior of ending each staff educational session with the reading of one vignette. The vignette is to be that of an obese patient's open-ended responses to daily fears or experiences concerning healthcare of themselves or their obese child.

Simulation

Collaborating with others in healthcare is a mandate for nurses. Learning from and re-teaching to others are opportunities for positive professional growth for the individual nurse and the profession. In the literature, we learned of a pioneering approach to weight bias reduction; obesity simulation (Hales et al., 2016). Let's recap. Garnered from our global nursing colleagues in New Zealand was a hands-on exercise in obesity comprehension; as we observed, study participants were assigned an obesity simulation

suit to wear while partaking in an interactive public task (Hales et al., 2016). Post-interventional measures displayed enhanced empathy and reduce judging of the obese. Therefore, my fifth and final interventional recommendation is incorporating obesity simulation into annual obesity sensitivity training for staff nurses of all levels. Nurses will be randomized regarding order of participating in the simulation suit exercise. Each nurse will be required to take part in this activity as a requisite of employment. Pre- and post-simulation open-ended questionnaires will be completed. In place of staff development meetings, staff focus groups will be held quarterly to analyze feedback from those who have recently undergone the suit training. Nurse researchers will maintain and regularly assess the survey data pertinent to efficacy of the exercise; correspondingly, the nurse researchers will lead the focus groups to ensure beneficial group dynamics and remaining on topic. Anticipated to be quite beneficial, this intervention will give nurses an exceptional opportunity to become strong advocates for eradicating weight bias; through sharing the impact of their short-lived experiences as an obese person with colleagues of other disciplines and the organization, headway towards social justice for this population will certainly be made.

<div align="center">**Strengths and Limitations of the Project**</div>

Strengths in this systematic review of weight bias begin with a comprehensive and unbiased summary of the best evidence available. Multiple studies representing the level of evidence pyramid from the summit to the base have been critically analyzed, compacted into brief synopses of purpose and findings, and provided to the reader. This review has incorporated a plethora of studies, accounted for bias, ensured outcome

reliability and validity, and is reproducible. The literature selected is both quantitative and qualitative with rich and detailed data, objective statistical findings and subjective personal experiences, and offers usefulness for evidence-based practice in generalizability to the target population with support of further research verified.

This review has established weight bias as a clinical problem. It is a problem nurses are not immune from. It is a healthcare problem across disciplines, a local and national problem, and a social injustice. Weight bias negatively impacts health as the review has repetitively displayed. Additionally, the literature has shown medical care given to obese patients, where bias is found, is of lesser quality than that given to normal weight patients. Lastly, this SR has contributed to the understanding of the antecedents of weight bias as well as demonstrated benefits of attempted intercessions.

The sparsity of number of studies on weight bias at the level of systematic reviews, meta-analyses or meta-syntheses, and randomized controlled trials is a limitation found in this SR. In addition, the preponderance of research inquests on weight bias is observational with subject level data and not eligible for the strongest ranking on the evidence pyramid. Nevertheless, weight bias is quite challenging to study with experimentation or manipulation of variables relevant to ethical concerns; consequently, the evidence presented in this SR does validate the call for further research on this topic.

A further limitation might be in the regards of some of the studies being specific to physicians rather than nurses. This can be viewed as constraining. Contrarily, it might also be considered contributory in its affirmation of weight bias not explicit to nursing. Bringing to light the interventional designs of nurses for weight bias eradication to be

conscious of incorporating other disciplines in collaboratory efforts to tackle a problem of such magnitude could be the push needed for improving the lives of the obese.

Future Projects

Weight bias is established in the evidence as indisputably present. Having this knowledge, nursing professionals must decipher how to intercede. Further research is not only supported but ought to be a requirement of nurses who care for the obese; most all nurses will be eligible. Studies of optimal interventions in weight bias are lacking. Investigations into educational training on the complexity of obesity causation, use of respectful spoken and unspoken language when caring for obese patients, and exemplifying those of excess weight who lead active and healthy lifestyles to alter negative stereotyping are recommendations for future projects in great demand.

Summary

Section 4 has strived to report the analysis and synthesis of several varied studies on weight bias with succinct findings, unanticipated outcomes, implications of the findings on different levels as well as their effects to positive social change. Quite a few recommendations and solutions to resolve the gap-in-practice are detailed and discussed at length. Furthermore, the strengths and limitations of the doctoral project are shared. Presented in conclusion are well-thought-out advisements for future projects anticipated most advantageous to address and resolve the harmful conduct of weight bias.

Section 5: Dissemination Plan

Introduction

The purpose of this DNP project was to perform an analytical and meticulous examination of the literature for a diverse representation of the best available scientific evidence concerning the presence and impact of weight bias. Objectives of myself included ascertaining the most suitable answers to the pre-determined practice-focused questions as well as offering a well-organized account of the problem in an endeavor to support the need for further research into addressing interventional actions.

Weight bias has no immunity in healthcare institutions. With this knowledge, nurses are in a position to exploit the problem and be the impetus for its absolution; the design of a no-tolerance weight bias campaign to come to life in the nursing discipline and fester to other healthcare fields is the beginning to a constitutive end to obesity discrimination. Implementing the interventions recommended by myself based on the findings of this study are stepping stones in this process; except, incorporation of such at the institutional level is beyond the scope of this project. Nevertheless, this project will be provided to the nursing educators of our local institution as an objective and evidential display of weight bias and call for change actions. Moreover, it will be shared with the management teams of the obesity medicine clinics as we learned that even those who treat patients with eating disorders are susceptible to negative bias (Puhl et al., 2014).

Disseminating this project to the broader nursing profession is most fitting. Weight bias is supported as presenting across all disciplines; additionally, obesity is prevalent in all healthcare settings. The usefulness of these findings and their

implications for intercession can be found in a generalizability that is extensive as the shared characteristics are existing in the nationwide population (Grove et al., 2013). Therefore, it would be more than appropriate to incorporate this study into nursing curriculum modification of cultural training with emphasis on humility as well as in professional staff development with the application of the recommended interventions. Nursing curriculums productive of licensed practical nurses through to those doctorally-prepared are venues in need of the distribution of the knowledge represented here. Furthermore, all nursing hiring organizations would benefit from making this information and the tactics advised within a requisite of onboarding and annual training for nursing professionals in active status of continued employment.

Analysis of Self

I am often asked why I am pursing a doctoral degree in nursing. It is a question that I pondered how to eloquently answer initially. Now I simply smile at the inquisitor and say "because I want to be the best of the best." Doctoral preparation brings an expectation of practicing with expertise (Zaccagnini & White, 2014). As a practitioner, my nursing role experienced a shift from one who assists the provider to being the provider. Progressing through a doctoral program will allow my nursing actions to again shift; embracing scholarly duties and identifying opportunities to be the advocate for positive change at a higher level are anticipated. In practice, long-term goals are developments that will impact the disease of obesity in epidemiological measures as well as discovery of alterations to the medical management of obesity on a national level. As a scholar of nursing, designing and completing the DNP project has equipped me with a

reference point to continue to build upon with aim of generating novel scientific evidence. Project management is a colossal element of the DNP project. Performing a systematic review of the literature provides experience in the investigation of a purported problem and its complete follow through to the development of evidence-based interventions (Zaccagnini & White, 2014).

As with most monumental tasks, the first look I took into what was entailed with this DNP project did catch me a bit thrown off. How was I going to do a DNP project of this magnitude in addition to classwork and practicum hours? It seemed unattainable. However, here I sit today writing the finality. Convincing myself the project would be achievable did not take place immediately nor on many occasions when there seemed very little time available. A sectional presentation and submission was my windfall. Had the project been designed to complete in full (without intermittent section turn-in), I would not have perceived successful progression. Believing I could push through to the end of each section did build confidence and an acceptance of an end in sight. I have discerned quite a bit from this educational obligation. Researching research is entertaining for the mind. Critiquing and analyzing studies specific to a problem one sees as necessary to solve assists in bringing a black and white picture to life with vibrant colors. Gleaning the degree of contributions to science from the efforts espoused in observational and experimental study accounts for the insight gained in this project.

Summary

The contributions of this literature review to healthcare are an increased awareness and understanding of weight bias and its influences on medical care. Both

short and long-term consequences of negative explicit and implicit weight bias are damaging to the physical and psychological health of the obese. Obesity is a chronic disease process that has continued to trend upwards in our nation; hence, more and more of our patients in nursing are and will continue to be obese. Established is the lack of resistance to bias from nursing professionals. With knowledge of this existing problem, nurses can become role models through activism for an end to the last socially acceptable form of discrimination: weight bias. Here, we observe a need for future research in design of interventions to absolve provider bias in healthcare. Nursing advocates can work together to create new standards for the approach to care of the obese inclusive of mandated weight sensitivity training with a humility framework. National sanctions prohibiting weight bias and discrimination are called for. Sanctions for prevention of racial prejudice have been embraced. Obesity is an illness causing a diversity in a person. This illness cannot be hidden. Accordingly, the obese person is equally deserving of respect and protection as is the racially divergent. It may be highly beneficial to focus additional research on the small number of healthcare providers who have been found to have no bias towards the obese. Further comprehending their cultural environments may assist nursing professionals in conceptualizing and constructing superlative evidence-based interventions aimed towards the elimination of weight bias.

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Appendix A: Tabular Article Presentation

First Author/ Year	Aim	Sample/ Setting	Design/ Intervention	Findings/ Limitations	LOE
Murphy, 2016	Examine scientific evidence of weight bias & stigma from pharmacists towards obese persons.	Search of 5 electronic databases conducted in Nova Scotia, CN	Systematic Review - Literature analysis of all published and grey literary works.	Evidence of implicit and explicit weight bias demonstrated by pharmacists. More study needed. – *(L)* English-only articles, limit of 100 articles searched.	I
Lee, 2014	Examine effectiveness of weight bias interventions & guide future research by comparison of the types of interventions.	Search of 3 electronic databases conducted in Tampa, FL	Meta-analysis – Literature assay of quantitative works.	A small, positive effect of the interventions on weight bias attitudes & beliefs with emphasis on attitude alterations. More study needed for new intervention tactics. – *(L)* Review limited to cognitive & affective findings.	I
Phelan, 2015	Assess medical school factors that affect weight bias in medical students.	1795 medical students throughout the US.	Prospective Cohort – Web-based weight bias surveys obtained at year one and end of year four of medical students.	Medical students implicit weight bias decreased while explicit weight bias increased throughout their education most strongly related to discrimination witnessed by faculty. More study needed to improve weight bias in new physicians. – *(L)*	V

				Unable to include measures of all potential influencing elements throughout medical school.	
Gudzune 2014	Examine effects of weight bias by primary care providers on patient weight loss.	600 overweight or obese adults in US.	Cross-sectional – Web-based one-time survey of subsequent weight loss attempts & success following experience of PCP weight bias.	More than 20 percent reported weight bias with lack of associated weight loss; significant weight loss reported when PCPs discussed weight with patient absent of judgment. More study into PCP weight communication skills training advised. – *(L)* Self-report data and bias perception limited to single query.	VI
Hales, 2018	Assess impact of obesity simulation intervention on weight bias in health professionals.	7 health professionals in New Zealand.	Pre-experimental – Pretest & posttest interviews on weight bias & stigma after wearing obesity simulation suit in public**.**	Increase empathy & reduced judgment of obese persons following intervention. More simulation study with all potential ethical aspects accounted for is needed. – *(L)* Study size & limited study control.	VI

Jackson, 2014	Identify association between weight bias and weight changes.	2944 men & women aged 50+ in the United Kingdom.	Ex post facto - Retrospective data review & comparison of weight changes before & after reported experiences of weight bias.	Experience of weight bias resulted in association with weight increase as well as waist circumference growth. Weight bias found to promote weight gain; more study to identify weight bias interventions. – (L) Threats to internal validity.	VI
Wong, 2015	Examine association between care given by providers to obese persons & minorities.	25,971 adult patients of US providers.	Ex post facto – Retrospective data review & comparison of provider communication quality given to whites versus the obese and minority populations.	No variance of care given to whites regardless of weight category; obese blacks and normal weight Hispanics report poorer quality of care with their providers. More study needed in communication that is tailored to obese & minorities. – (L) Self-reported data. Lack of control of provider features.	VI
Richard, 2014	Examine variation in primary care physician communication to obese persons.	6,628 adult patients of US primary care physicians.	Ex post facto - Retrospective data review & comparison of primary care physician communication given to obese versus non-obese patients.	Overall reduced scores of physician communication efficacy to obese persons with emphasis on less respect, empathy, and active listening skills when	VI

			compared to normal weight persons. More study needed to identify weight sensitivity interventions for physicians & more efforts in national policy to combat obesity needed. – *(L)* Self-reported data, possible limited clinical usefulness.	
Tomiyama, 2015	Investigate weight bias in obesity researchers and obesity-related professionals & examine level of change in implicit and explicit weight bias since 2001.	232 adult ObesityWeek attendees in Georgia in 2013.	Cross-sequential – Surveying performed inclusive of Implicit Association Testing with comparison to data obtained from similar attendees of 2001 conference.	Implicit bias remains significant in both obesity-related cohorts, yet, reduced in 2013; explicit bias increased in the 2013 cohort when compared to the 2001 cohort. Future research on pressure of providers to achieve weight loss in patients needed as is conjectured to be impetus for both forms of bias. – *(L)* Samples are not directly comparable.	VI
Wakefield, 2017	Examine the impact of weight bias from healthcare professionals on obese patients.	1 adult female obese patient in Australia.	Case study – Longitudinal description of detriment of repeated weight bias from	Display of physical & psychological impact of weight bias inclusive of weight gain, loss	VI

			healthcare professionals	of self-worth, & social withdrawal. More study needed to address weight discrimination by healthcare professionals. – *(L)* Self-report bias.	
Latner, 2014	Examine the relationship between weight bias & health-related quality of life (HRQoL) in female obese persons.	81 adult females of mixed international settings.	Descriptive Survey – Combination of three weight bias & health perception questionnaires completed online by each participant & statistically analyzed.	Significant association between weight bias & physical HRQoL, BMI not related to physical health impairment with low levels of weight bias. More research needed to reduce weight stigma & assist patients with weight bias experiences, Health at Every Size recommended. – *(L)* Non-representative sample, self-reported data.	VI
O'Brien, 2016	Examine association between weight stigma and disordered eating behaviors in normal & overweight persons.	634 adult university students in Australia.	Descriptive Comparative Survey - Combination of four weight bias & disordered eating behavior surveys completed online by participants placed in two groups: normal	Weight stigma associated with all three disordered eating behaviors (emotional, uncontrolled, and loss-of-control eating) and increased psychological distress consequent to increased	VI

			weight or overweight. Statistical analysis performed on obtained data.	disordered eating behavior. More study needed to clarify the progression of the association, interventions for weight stigma, & anti-weight stigma policy creation for schools, work and medical settings. – *(L)* Homogeneity of sample, less generalizability.	
Bombak, 2016	Examine lived experiences of female obese patients in access & receipt of healthcare.	24 adult female patients of reproductive healthcare in Canada.	Descriptive Survey – Semi-structured in-person qualitative interviews focused on behaviors & attitudes experienced by healthcare professionals.	Overall access & receipt of care described as limited & insensitive precise to being negative, humiliating, stigmatizing, oppressing, & discriminatory. Outright refusal to offer care experiences not uncommon. More study needed for reducing general obesity stigma in healthcare as well as additional focus on womens health. – *(L)* Lack of purposive sampling & small sample size.	VI

Waller, 2012	Assess implicit weight bias in healthcare students.	90 nursing & psychology university students in Alaska.	Descriptive Survey – In-person Implicit Association Testing (IAT) completed by each participant.	Consistent implicit weight bias displayed and found congruent of nursing & psychology students; stronger weight bias observed towards females. More research needed to link weight bias testing outcomes with weight bias behaviors with a focus on female bias prevalence and identity of interventions. – (L) Convenience sampling led to lack of heterogeneity.	VI
Garcia, 2016	Identify weight bias in pediatric nurses & support staff.	574 RNs & clinical staff members in a pediatric hospital in Florida.	Cross-sectional Survey – Nurses' Attitudes toward Obesity and Obese Patients Scale completed online.	Nursing weight bias observed with beliefs of obesity being controllable & stereotypic characterizing of obese patients. More research in bariatric sensitivity education, weight bias studies, & interventions to reduce victim blaming needed. – (L) Convenience sampling, low study response rate.	VI

Ratanapichayachai, 2017	Assess weight bias & features in health professionals.	301 nurses, clinical staff, & physicians in training in Thailand.	Descriptive Comparative Survey – Questionnaires inclusive of the 3 following scales completed by participants: Attitudes Toward Obese Persons (ATOP), Fat Phobia (FPS), & Beliefs About Obese People (BAOP).	Weight bias prevalent among all health professionals; significance of more negative obese attitudes in physicians in training compared with nurses & support staff, significance in more negative obese attitudes in men compared with women. More study in weight bias interventions targeted towards physicians & male health professionals needed. – *(L)* Convenience sampling.	VI
Puhl, 2014	Assess weight bias in health professionals who treat eating disorders.	329 mental health professionals specializing in eating disorders in the US.	Descriptive Survey – Combination of ATOP & FBS scales with additional queries completed anonymously online.	Weight bias present & similar to degree in other health professionals with pessimism regarding treatment outcomes. More study needed in interventions to educate causality of obesity. *(L)* – High attrition.	VI
Phelan, 2014	Examine weight bias in comparison to other types of	4732 medical students in the US.	Longitudinal Survey – Combination of 6 measures of weight bias	Moderate to strong implicit weight bias observed with high prevalence	VI

|				
	bias in medical students.		including the IAT completed online by each participant with data from the Cognitive Habits and Growth Evaluation Study of Medical Students.	of explicit weight bias, weight bias dominant in comparison to biases associated with race, ethnicity, sexual status, & income level. Greater weight bias in men than women. More research needed to develop weight bias interventions in medical schooling. – *(L)* Participation bias.	
Puhl, 2014	Examine weight bias in healthcare students.	107 healthcare students in post-graduate study in the US.	Descriptive Survey – Combination of 7 measures of weight bias inclusive of the FPS & ATOP scale completed in-person.	Weight bias common among healthcare students both implicit & explicit with high percentage of acceptability of derogatory humor aimed towards obese persons & frustration with the provision of care. More research needed to assess weight bias attitudes & contributory knowledge in students in health disciplines to reduce barriers to care of the obese. – *(L)* Lack of	VI

				randomization in sample, homogeneity reducing generalizability.	
Wang, 2016	Examine weight bias in nurses.	297 female community health RNs in China.	Descriptive Survey – Combination of 3 questionnaires inclusive of the ATOP scale, the External Weight Locus of Control scale, & the Dieting Belief scale completed on paper.	Overall **positive** attitudes observed toward obese persons with belief of obesity being out of personal control. More research to identify underpinnings of weight bias between the East & the West needed. – *(L)* Convenience sampling, self-report data.	VI
Nichols, 2015	Assess relationship of weight bias in student nurses to personal BMI and level of patient advice & care.	92 student nurses in the United Kingdom.	Cross-sectional Survey – Combination of 2 questionnaires inclusive of the FPS & a response set to vignettes completed online.	Weight bias displayed to **not** be associated with lesser level of advice or care given. Also, no associations found between student nurses, their personal BMI, & weight stigma. More study in potential culture shift as displayed in UK nurses in blocking weight bias from patient care rather than ongoing global efforts to prohibit the bias. – *(L)*	VI

				Homogeneity of sample,	
Fruh, 2016	Examine weight bias & stigmatization in the health provider setting.	Presentation of obesity experts in academia & Obesity Action Coalition in US.	Peer-reviewed article.	Weight discrimination has risen 66 percent in last decade; NPs to lead way in impact on weight bias through self-awareness & role modeling empathetic approach to obesity care. More study needed in enhancing NP education for elimination of obesity bias. – *(L)* Homogeneity of authors.	VII
Alberga, 2016	Report synopsis of Canadian Weight Bias Summit & inspire weight bias collaboration globally.	Presentation of nutrition & public health experts & Canadian Obesity Network in Canada.	Peer-reviewed article.	Weight bias prevalent internationally with limited research on how to reduce. Efforts to end weight discrimination need three-part focus from practitioners & researchers: altering to person-first language in healthcare, incorporating voices of lived experiences in healthcare delivery & qualitative	VII

				research, & requisite to collaborate interdisciplinary for uniform change across disciplines. More study needed in effective policy making that includes the voices of the obese is needed. – (L) Participation bias.	
Giese, 2016	Address weight bias & stigma in health providers & ethical responsibility.	Presentation of nursing expert in US.	Peer-reviewed article.	Weight bias prevalent in society & present in healthcare providers. NPs to self-reflect, implement Christopher Johns Model for Structured Reflection, & offer ethically-sound care for vulnerable with objective of elimination of provider weight bias. – (L) Limited expert opinion.	VII
Nutter, 2016	Examine weight bias perspectives & weight-based social inequity.	Presentation of academia & health experts in Canada.	Peer-reviewed article.	Weight bias present in healthcare providers & across society. Overall causality belief is in individual control; such is detrimental to	VII

				impacting change. More study in educational interventions for public & providers is needed as well as mandate of weight bias as social justice issue necessary of parliamentary interest. – *(L)* Participation bias.	
Nazione, 2015	Examine effects of medical provider weight bias.	Presentation of academia expert in US.	Peer-reviewed article.	Provider weight bias is increasing health inequalities; providers who perceive individual control as factor of obesity have greater bias. Conscious self-reflection required prior to care of obese patient. More study needed to identify educational interventions involving obese persons' testimonials for medical students & providers. – *(L)* Limited expert opinion.	VII

Appendix B: Levels of Evidence Pyramid
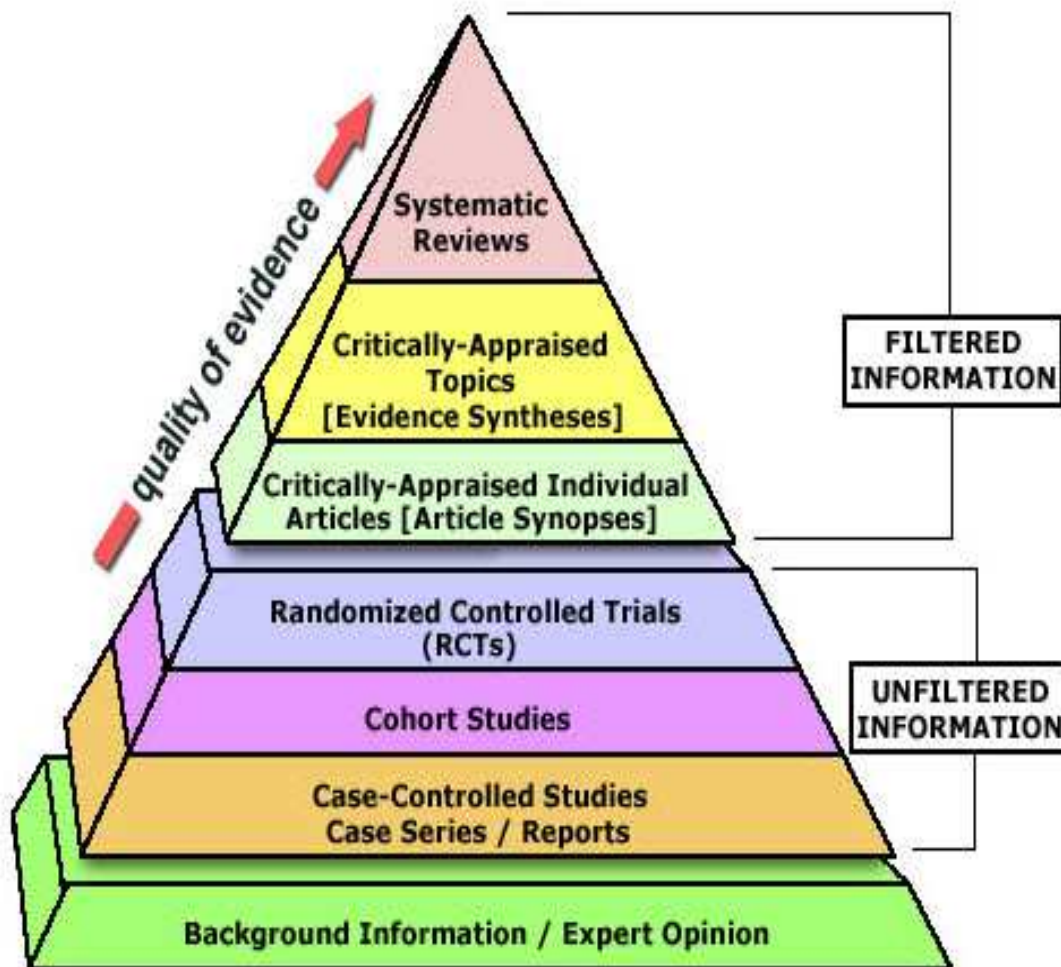
Source: Walden University. (2006). *Evidence-based practice research: Levels of evidence pyramid* (Educational standard per Trustees of Dartmouth College and Yale University). Retrieved from https://academicguides.waldenu.edu

Appendix C: Newcastle-Ottawa Quality Assessment Scale

Note: A study can be awarded a maximum of one star for each numbered item

within the Selection and Outcome categories. A maximum of two stars can be

given for Comparability Section.

SELECTION

1) Representativeness of the exposed cohort

a) truly representative of the average _____ (describe) in the

community*

b) somewhat representative of the average _____ in the community

c) selected group of users eg nurses, volunteers

d) no description of the derivation of the cohort

2) Selection of the non-exposed cohort

a) drawn from the same community as the exposed cohort*

b) drawn from a different source

c) no description of the derivation of the non-exposed cohort

3) Ascertainment of exposure

a) secure record (e.g, surgical records)*

b) structured interview*

c) written self report

d) no description

4) Demonstration that outcome of interest was not present at start of study

    a) yes

    b) no

COMPARABILITY

1) Comparability of cohorts on the basis of the design or analysis

    a) study controls for _____ (select the most important factor)

    b) study controls for any additional factor* (These criteria could be modified to

    indicate specific control for a second important factor.)

OUTCOME

1) Assessment of outcome

    a) independent blind assessment*

    b) record linkage*

    c) self-report

    d) no description

2) Was follow-up long enough for outcomes to occur

    a) yes (select an adequate follow up period for outcome of interest) *

    b) no

3) Adequacy of follow up of cohorts

    a) complete follow up - all subjects accounted for*

    b) subjects lost to follow up unlikely to introduce bias - small number lost - >

    _____ % (select an adequate %) follow up, or description provided of those lost)

c) follow up rate < _____% (select an adequate %) and no description of those lost

d) no statement

Source: Wells, G. A, Shea, B., O'Connell, D., Peterson, J., Welch, V., Losos, M., & Tugwell, P. (2014). *The Newcastle-Ottawa scale (NOS) for assessing the quailty of nonrandomised studies in meta-analyses.* Retrieved from http://www ohri ca/programs/clinical_epidemiology/oxford.asp

Appendix D: Newcastle-Ottawa Scale Findings

Nonrandomized studies

First Author/Year	Study Design	Stars Awarded per NOS
Phelan, 2015	Prospective cohort	8
Gudzune, 2014	Cross-sectional	6
Hales, 2018	Repeated measures pretest/posttest	8
Jackson, 2014	Ex post facto retro	8
Wong, 2015	Ex post facto retro	8
Richard, 2014	Ex post facto retro	9
Tomiyama, 2015	Ex post facto retro	9

Appendix E: Implicit Association Test

To take the Implicit Association Test, please go to the Harvard Website:

https://implicit.harvard.edu

There are many implicit test subject matters; please choose weight.

Noted, this test is used for self-reflection and educational purposes. It is based on your

underlying word and visual associations. Implicit testing can divulge unconscious

preferences or beliefs one is unwilling to share; either may lead to behaviors of

discrimination (Harvard University, 2011).

Source: Harvard University. (2011). *Project implicit.* Retrieved from

https://implicit.harvard.edu

Appendix F: BAOP: Beliefs About Obese Persons Scale

Please mark each statement below in the boxes to the right, according to how much you agree or disagree with it. Please do not leave any blank. Use the numbers on the following scale to indicate your response. Be sure to place a minus or plus sign (- or +) beside the number that you choose to show whether you agree or disagree.

-3	-2	-1	+1	+2	+3
I strongly disagree	I moderately disagree	I slightly disagree	I slightly agree	I moderately agree	I strongly agree

1. Obesity often occurs when eating is used as a form of compensation for lack of love or attention.

2. In many cases, obesity is the result of a biological disorder.

3. Obesity is usually caused by overeating.

4. Most obese people cause their problem by not getting enough exercise.

5. Most obese people eat more than non-obese people.

6. The majority of obese people have poor eating habits that lead to their obesity.

7. Obesity is rarely caused by a lack of willpower.

8. People can be addicted to food, just as others are addicted to drugs, and these people usually become obese.

Source: Allison, D. B., Basile, V. C., & Yuker, H. E. (1991, September). The

measurement of attitudes toward and beliefs about obese persons. *International Journal*

Eating Disorders, 10, 599-607. doi: 10.1002/1098-108X(199109)10:5<599::AID-

EAT2260100512>3.0.CO;2-#

Appendix G: The Obesity Society Resource for Healthcare Providers

1. Consider that patients may have had negative experiences with other health professionals regarding their weight and approach patients with sensitivity.

2. Recognize the complex etiology of obesity and communicate this to colleagues and patients to avoid stereotypes that obesity is attributable to personal willpower.

3. Explore all causes of presenting problems, not just weight.

4. Recognize that many patients have tried to lose weight repeatedly.

5. Emphasize behavior changes rather than just the number on the scale.

6. Offer concrete advice (eg, start an exercise program, eat at home, etc., rather than simply saying "You need to lose weight").

7. Acknowledge the difficulty of lifestyle changes.

8. Recognize that small weight losses can result in significant health gains.

9. Create a supportive health care environment with large, armless chairs in waiting rooms, appropriately-sized medical equipment and patient gowns, and friendly patient reading material.

   It is also useful to identify one's own bias. Asking the following questions can be helpful in this regard:

10. Do I make assumptions based only on weight regarding a person's character, intelligence, professional success, health status, or lifestyle behaviors?

11. Am I comfortable working with people of all shapes and sizes?

12. Do I give appropriate feedback to encourage healthful behavior change?

13. Am I sensitive to the needs and concerns of obese individuals?

14. Do I treat the individual or only the condition?

Source: Fruh, S. M., Nadglowski, J., Hall, H. R., Davis, S. L., Crook, E. D., & Zlomke,

K. (2016, July/August). Obesity stigma and bias. *Journal for Nurse Practitioners, 12*(7),

425-434. doi: 10.1016/j.nurpra.2016.05.013