Transcript for Prominence Weight Bias and Stigma – Unit 2: Recognising weight stigma and bias in practice

Slide 1:

Welcome to Unit 2 of OSE4ALL Obesity Stigma Education for all Healthcare Professionals.

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This resource is developed for PROMINENCE by UCD MEMBERS of the OSE4ALL partnership.

Slide 2:

UNIT 2 - 2.1 Recognising weight stigma, weight bias and weight discrimination in practice

Weight stigma and bias can influence clinical judgement and treatment. So, in unit 2, we'll look at stigma, reflect on our own biases, and work toward recognising and changing discriminatory practices in healthcare delivery.

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UNIT 2 - 2.2 Learning outcomes

At the end of this unit, you should be able to define key terms, identify different types of weight bias, understand how they appear in clinical settings, and reflect on **how** your own assumptions can shape patient interactions and decision-making.

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UNIT 2 - 2.3 What is weight stigma, weight bias and weight discrimination?

As healthcare professionals, it's important to understand what we mean by weight stigma weight bias, and weight discrimination.

Weight stigma refers to negative stereotypes about obesity and people living in larger bodies.

Weight bias describes our own individual attitudes and beliefs about obesity and people living in larger bodies.

Weight discrimination happens when we act on our biases and treat people living in larger bodies unfairly.

Weight bias is prevalent in healthcare and healthcare education, and can create significant barriers to effective care. Many patients report experiencing weight stigma from doctors, nurses, psychologists, dietitians, physiotherapists and other professionals. Understanding these, we can work toward providing equitable care.

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UNIT 2 - 2.4 Types of weight bias in healthcare

Let's break down three key forms of weight bias that lead to discrimination and poor outcomes in healthcare: explicit, implicit, and internalised bias.

Explicit weight bias is defined as having overtly negative attitudes toward people with obesity [1]. Examples include:

Assumptions that people living with obesity are lazy, unmotivated, lacking self-discipline or willpower and non-compliant with medical treatment.

Implicit weight bias is when clinicians have subconscious negative attitudes about people with higher weight. We're not aware of holding implicit bias, and we don't realise how this influences our **judgements, decisions and behaviours**. Nonetheless, this can be harmful. An example is:

When clinicians use phrases such as 'the patient failed to lose weight' or 'they are in denial about their weight', or 'morbidly obese'. Clinicians don't use terms like 'failed', 'in denial' or 'morbidly' when referring to people with other chronic diseases, such as high blood pressure or asthma.

Internalised Weight Bias is the most harmful bias, where negative society stereotypes are internalised, and directed against oneself. People who have high weight bias internalisation tend to believe that they deserve the negative attitudes or negative treatment they receive. An example is:

When a patient believes they don't deserve support or treatment to manage their weight because they believe it is 'self-inflicted' or 'they should be able to do it themselves'. They may not ask for multidisciplinary or specialist support, or take prescribed medication.

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UNIT 2 - 2.5 How does weight bias manifest in healthcare?

Weight bias shows up in several key ways and has a measurable impact on patient care and outcomes.

First, **diagnostic overshadowing,** where symptoms are attributed to weight rather than fully investigated results in **delayed or missed diagnoses**. For example, joint pain, fatigue, even breathlessness may be dismissed as weight-related, go un-investigated delaying diagnoses.

Patients experience **limited access to, or delayed treatment**, for example when told 'lose weight and come back,' even when the issue is unrelated. Patients are sometimes denied necessary care based solely on weight.

Negative interpersonal interactions, such as judgmental verbal and body language, assumptions about lifestyle, or reduced empathy, undermine trust. Many people with obesity report feeling judged, disrespected, and not listened to [2, 3] [4-7]. When patients have previously felt dismissed, they're less likely to attend appointments, screenings, or follow-up care. Leading to delays in diagnosis, poorer disease management, and worse health outcomes overall.

Patient avoidance is another key consequence. In Ireland, people wait an average of eight years before discussing weight concerns with a healthcare professional [3, 4, 8].

Inadequate equipment, including non-fitting gowns, blood pressure cuffs, seating or exam tables, or imaging machines, cause discomfort, compromises dignity, and can lead to inaccurate clinical data.

Finally, **bias in structures and policies** can reinforce unequal care at a system level, such as rigid BMI cutoffs for procedures, limited training in weight-inclusive care, stigmatising documentation, and lack of cover or reimbursement for evidence-based treatments.

These findings remain significant even after accounting for factors such as age, gender, BMI, and past experiences of stigma [3].

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UNIT 2 - 2.6 Weight stigma and bias in physiotherapy practice

In physiotherapy practice, assumptions about motivation, fitness, effort, or deconditioning can influence assessment, clinical reasoning, and

treatment decisions, shaping interpretation of pain, **symptoms** and complications, and influencing which interventions are offered and how they are progressed.

Patients may feel exposed or vulnerable during undressing, exercise, manual handling, positioning, or use of assistive equipment, particularly when dignity and psychological safety are not prioritised.

Internalised stigma, such as beliefs about personal responsibility, feeling undeserving of care, or anticipating judgement, can reduce confidence and engagement.

Pain and prior **negative healthcare or activity experiences** may further reduce self-efficacy, amplify pain, and increase fear-avoidance.

Physiotherapists also manage the downstream effects of discriminatory practices, such as weight-based refusal of surgery, which can increase disability, limit mobility, and restrict engagement in physiotherapy care.

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UNIT 2 - 2.7*: *What are the health effects of weight stigma?

Weight stigma has physiological, psychological, and behavioural consequences that directly adversely impact health.

First, weight stigma triggers the body's stress response. When people experience or anticipate judgement, cortisol rises, and blood pressure, glucose, and inflammatory markers increase, key risk factors for cardiovascular and metabolic disease.

Weight stigma increases anxiety, causes psychological distress and further internalises weight bias.

Together these physiological and psychological effects, can actually promote weight gain. Elevated stress hormones, low mood, and internalised bias are linked with coping behaviours such as binge eating, and meal skipping, contributing to metabolic dysregulation and further **weight increase.**

Experience of stigma is also associated with reduced engagement in physical activity and social participation, further limiting opportunities for movement, affecting health and wellbeing.

The key takeaway is that weight stigma is an independent determinant of health, contributing to adverse physical and mental health outcomes, regardless of body size or BMI.

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UNIT 2 - 2.7*:1 *Patient voice

Take a moment to read what patients say about our verbal and non-verbal communication,

2.7*:2 *Patient voice

about how that makes patients feel and delays care,

2.7*:3 *Patient voice

and the effect we can have on behaviour and mental health.

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UNIT 2 - 2.8*: *Reflect

Now that we have seen what patients say, our patients' voices let take time to reflect on our own practice.

This topic is uncomfortable. No one likes examining their biases. But the reality is **we** all have them. Our attitudes are shaped by the world we live in: our culture, environment, and media. Healthcare providers are not immune to these influences.

If you've ever believed that obesity is simply a matter of "eat less, move more," this content may feel challenging. That's okay. The goal is awareness, not blame.

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UNIT 2 - 2.9: Reflect and take away

What automatic assumptions do you make when you see someone living in a larger body?

Question those assumptions. Then reflect.

How might those assumptions influence how you speak, how you listen, or the care you provide?

Think about how you manage your own bodyweight and size. Do you hold any internal bias? Or do you judge others by **your** behavioural efforts and **your own** neurobiological physiology – not theirs?

These thoughts are often automatic, outside our immediate control, but reflection gives us the opportunity to change how we behave.

We can choose to improve how we interact with patients: the language we use, the interventions we offer, and the respect and empathy we communicate through tone, body language, and active listening.

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***UNIT 2* - 2.10: Invite to Unit 3**

With training and greater self-awareness, weight bias in clinical practice can be reduced. And by using respectful, person-first language, offering non-judgemental care, combined with a disease-model approach and evidence-based interventions, we can improve health outcomes and quality of life for people living with obesity.

Next in Unit 3, we'll focus on how we as healthcare professionals, can communicate empathy, respect, and a commitment to delivering equitable, person-centred care.

UNIT 2 Resources

- **Explicit implicit internalised biases** [1] [2]
- **Weight stigma manifestations in healthcare** [3, 4] [5-9] [10]
- **Weight stigma health effects** [11-14] [15-20] [21, 22]
- **Patient voice references** [3, 23, 24]

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