International Journal of Research in Medical Sciences
Abdel Reheim NM et al. Int J Res Med Sci. 2017 Nov;5(11):4697-4700
www.msjonline.org
pISSN 2320-6071 | eISSN 2320-6012

DOI: http://dx.doi.org/10.18203/2320-6012.ijrms20174918

Original Research Article

Weight bias among health care providers for children in UAE

Naguib M. Abdel Reheim[1]*, Nehad Gomaa Ramadan Ali[1], Shaf Khot[1], Motahareh Vamegh[2], Mohammad Anwar[1], Mamdouh Swilem[3]

[1]Department of Pediatrics, University Hospital Sharjah, Adjunct staff at University of Sharjah, United Arab Emirates
[2]College of Medicine, University of Sharjah, United Arab Emirates
[3]Department of Pediatrics, Al Baraha hospital, Adjunct staff at University of Sharjah, United Arab Emirates

Received: 20 August 2017
Accepted: 20 September 2017

***Correspondence:**
Dr. Naguib M. Abdel Reheim,
E-mail: naguib.reheim@uhs.ae

ABSTRACT

Background: This research looks at weight bias among healthcare providers for children in UAE.
Methods: This study was done through self-administered questionnaire. Our targets were health care providers for children working in both governmental and private hospitals in UAE. 198 participants were enrolled in the study after exclusion of invalid questionnaires.
Results: While 15.4% of healthcare professions in our study acknowledged practice of weight bias during care of obese children, 52.5% denied and 32.1% are not sure about it. 149 participants (76%) believed that failure of obesity management in children is attributed to their weak willpower and poor commitment. Compared with normal children, overweight/obese children are considered less complaint by 59% of our participants, less active by 78.2%, less willpower by 59.5%, less confident by 73.2% and less intelligent by 17.7%. Finally, 10% of our participants consider treatment of overweight/obesity is a waste of time.
Conclusions: This study shows significant weight bias among healthcare profession which can occur unintentionally. Weight bias among health care providers affects the quality of medical care of obese children. Education, training and increasing awareness of weight bias among health care providers in UAE is an initial and essential step to decrease the risk of weight bias which is a significant barrier in management of childhood obesity.

Keywords: Children, Obesity, Physicians, Weight bias

INTRODUCTION

Obesity is a common global disease. In UAE 30% of children between 2-18 years are either overweight or obese.[1] Weight bias refers to the negative attitudes toward obese children only because of their weight. It is widely prevalent in media, schools, families, peers, employment and even in health care settings. Weight bias has adverse physical, social and psychological effects that are preventable. Physicians like other people in the community can sometimes practice weight bias with their obese children consciously or unconsciously. Research shows that even healthcare professionals who specialize in the treatment of obesity hold negative attitudes.

Beside the effects on the psychological, social, physical health, and quality of life of obese children weight bias in health care settings may have a negative impact on quality of healthcare provided for these patients. The more the weight of the patient, the more negative the attitudes and distancing behaviours of physicians.[2,3] This research looks at weight bias among healthcare providers for children in UAE.

METHODS

This cross sectional observational study was done through a self-administered questionnaire. The questionnaire was designed to cover various aspects of weight bias. A pilot study was done prior to distribution of the questionnaires. Our targets were health care providers for children working in both governmental and private hospitals in UAE. 198 participants were enrolled in the study after exclusion of invalid questionnaires. The health care professions voluntarily participated in this study and a consent form was provided. SPSS 21 program was used for analysis of data and pie and bar charts were used to represent results of this study. The Ethics Committee waived requirements for an ethical approval procedure.

RESULTS

198 participants were enrolled in the study after exclusion of invalid questionnaires. 70 of participants (37%) were from Private hospitals while 63 (34%) from Government hospitals, 22(11%) from polyclinics, 12 (6%) from private clinics and the remaining were from PHCs and other health care settings.

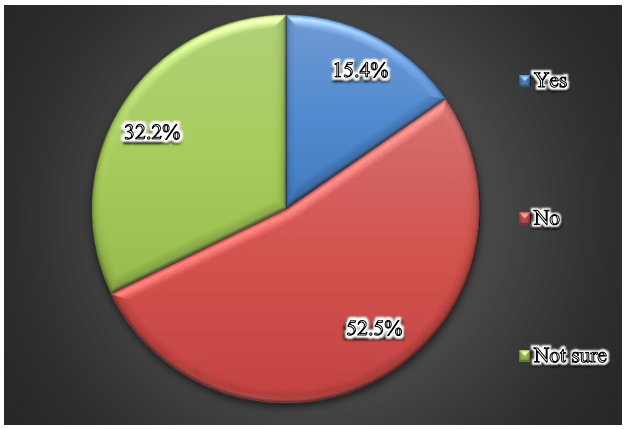


Figure 1: Acknowledging weight bias in professional environment.

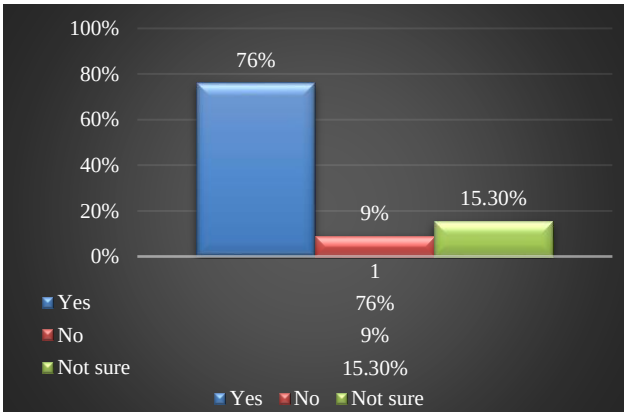
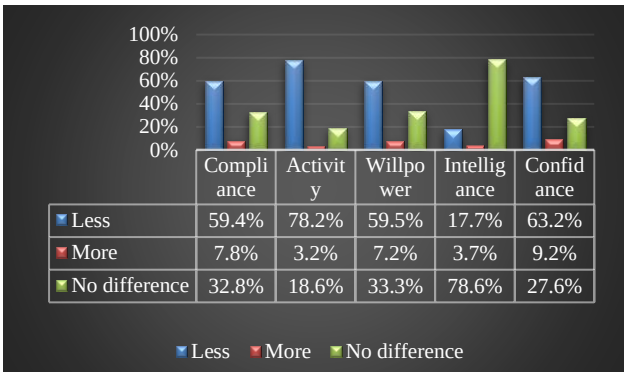


Figure 2: Failure of obesity management is due to "Lack of willpower" in obese individuals.

104 of health care professions in our study (52.5%) denied any weight bias in their facility, 64 participants (32.1%) were not sure about it while only 30 individuals (15.4%) acknowledged practice of weight bias (Figure 1).

149 participants (76%) believed that failure of obesity management in children is attributed to their weak willpower and poor commitment (Figure 2).

Compared with normal children overweight/obese children are considered less complaint by 90(59%) of our participants, less active by 155(78.2%), less willpower by 119(59.5%), less confident by 145(73.2%) and less intelligent by 35(17.7%) (Figure 3).



	Compliance	Activity	Willpower	Intelligance	Confidance
Less	59.4%	78.2%	59.5%	17.7%	63.2%
More	7.8%	3.2%	7.2%	3.7%	9.2%
No difference	32.8%	18.6%	33.3%	78.6%	27.6%

Figure 3: Healthcare professionals' perception of overweight/obese children in comparison to normal weight children.

Although in only 8% of our participants believe that overweight or obesity negatively affect their respect toward children and in (4%) of them it leads to have negative attitude toward these children while discussing weight issues with their parents, most of them (96%) believed that obese children need emotional support (Psychological or motivational). Finally, 10% of our participants consider treatment of overweight/obesity is a waste of time.

DISCUSSION

This study shows that weight bias- which is negative attitudes toward obese children only because of their weight- is quite common among health care providers caring for children.

It also shows that it can affect the quality of medical care offered to these children and their compliance to treatment.

This is clear from the high percentage of pre-assumptions among health care providers regarding many characters of obese children like defects in activity (78.2%), will power (59.5%), Confidence (59%) and even intelligence (17.7%). These pre-assumptions are based on no logic reason except of being overweight or obese.

These pre-assumptions can clearly affect the management of these patients as most of the participants believe that failure of treatment is related to these patients' assumed characters ignoring that childhood obesity is a complex disease caused by interactions of many biological, genetic, cultural and environmental factors that all needed to be tackled at the same time 4.

These assumptions can even lead to some participants to believe that treatment of such patients is a waste of time as reported by 10% of our participants.

These negative attitudes can also affect the respect and the relations between the health care providers and these obese children and their parents, this was acknowledged by 8% of our participants. With such attitudes, usually Less time is spent with the physician, with less intervention and less discussion with the parents.

The blame attitude of weight bias that practiced by health care providers-as they believe that failure of treatment is usually attributed to the patients weak will power- will lead the patients to avoid follow up in such clinics with poor compliance for treatment or any other therapeutic measures. Many of the patients will become reluctant to seek medical care, cancel medical appointments, and may be more likely to delay important preventative healthcare services.

Another important finding in this this study is that many of the health care providers are practicing weight bias unconsciously. This is clear from the discrepancy between the high percentages of the participants (average 60-70%) who have negative attitude towards obese children compared with the low percentage (15%) who acknowledge that they may practice weight bias during their care of these children. Many of them are even not sure about the attitudes of weight bias (32%)

Many other studies showed similar results. Negative attitudes about individuals with excess weight have been reported by physicians, nurses, dietitians, psychologists and medical students.[5-8]

Some researches showed that even healthcare professionals who specialize in the treatment of obesity hold negative attitudes.[9] In one study 2,449 overweight and obese women were surveyed for a list that include 22 different individuals (e.g., family members, employers, doctors, educators, strangers) and asked how often they were sources of weight stigmatization. 52% reported doctors had stigmatized them on more than one occasion.[10]

In other studies physicians viewed obese patients as: non-compliant, lazy, lacking in self-control, weak-willed, dishonest, unsuccessful, unintelligent.[11-15]

The importance of weight bias by health care providers does not arise only from its high prevalence but also from its important effects on our obese patients. Weight bias is known to have negative consequences for psychological, social, and physical health, as well as quality of life. This was shown in many studies.[16] Psychological outcomes can include depression, anxiety, low self-esteem, Poor body image, and suicidal thoughts and behaviors.[17] The social effects include social rejection by peers, poor quality of interpersonal relationships, and potential negative impact on academic outcomes.[18-22]

Weight bias can also lead to binge-eating, avoidance of physical activity and unhealthy weight control practice which will affect the physical health of obese children.[11,23,24]

CONCLUSION

Weight bias is a negative attitude that practiced against obese children only because of their weight. Weight bias is usually unrecognized complication of obesity in children although it has adverse physical, social and psychological effects and can affect the quality of life of these children. Although weight bias is preventable it is widely prevalent in media, schools, families, peers, employment. Unfortunately, weight stigma also exists in healthcare settings.

Physicians are common sources of stigma and research shows that even healthcare professionals who specialize in the treatment of obesity hold negative attitudes.

Weight bias among health care providers affects the quality of medical care of obese children leading to poor compliance for treatment or any other therapeutic measures. Many of them will become reluctant to seek medical care, cancel medical appointments, and may be more likely to delay important preventative healthcare services.

This study also shows that health care providers can and should play a critical role to reduce weight bias in health settings instead of promoting it. An initial and important step is that they should be aware of their own use of language, assumptions and attitudes about obese children. Also, they should understand the nature of obesity as a complex disease caused by many biological, social, cultural and environmental factors which will make them avoid the blame attitude and using an encourage one instead during their management.

Health educations, increased awareness of weight bias and training health care providers on the skills of communications during dealing with obese children are recommended in UAE for any trial to prevent weight bias among health care providers.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: Not required

REFERENCES

1. Prevalence of overweight and obesity among children in the United Arab Emirates. Obes Rev. 2007;8(1):15-20.
2. Hebl MR, Xu J. Weighing the care: physicians' reactions to the size of a patient. Int J Obes Relat Metab Disord. 2001;25:1246-52.
3. Harvey EL, Hill AJ. Health professionals' views of overweight people and smokers. Int J Obes Relat Metab Disord. 2001;25:1253-61.
4. Spruijt-Metz D. Etiology, treatment, and prevention of obesity in childhood and adolescence: A decade in review. Journal of research on Adolescence. 2011;21(1):129-52.
5. Young LM, Powell B. The effects of obesity on the clinical judgments of mental health professionals. Journal of Health and Social Behavior. 1985:233-46.
6. Foster GD, Wadden TA, Makris AP, Davidson D, Sanderson RS, Allison DB, et al. Primary care physicians' attitudes about obesity and its treatment. Obesity. 2003;11(10):1168-77.
7. Oberrieder H, Walker R, Monroe D, Adeyanju M. Attitude of dietetics students and registered dietitians toward obesity. Journal of the American Dietetic Association. 1995;95(8):914-6.
8. Keane RM. Contemporary beliefs about mental illness among medical students: Implications for education and practice. Academic psychiatr. 1990;14(3):172-7.
9. Schwartz MB, Chambliss HO, Brownell KD, Blair SN, Billington C. Weight bias among health professionals specializing in obesity. Obesity. 2003;11(9):1033-9.
10. Campbell M, Fitzpatrick R, Haines A, Kinmonth AL, Sandercock P, Spiegelhalter D, et al. Framework for design and evaluation of complex interventions to improve health. BMJ. 2000;321(7262):694.
11. Puhl RM, Brownell KD. Confronting and coping with weight stigma: an investigation of overweight and obese adults. Obesity. 2006;14(10):1802-15.
12. Hebl MR, Xu J. Weighing the care: physicians' reactions to the size of a patient. Internat J Obesit. 2001;25(8):1246.
13. Kristeller JL, Hoerr RA. Physician attitudes toward managing obesity: differences among six specialty groups. Preventive medicine. 1997;26(4):542-9.
14. Maiman LA, Wang VL, Becker MH, Finlay J, Simonson M. Attitudes toward obesity and the obese among professionals. Journal of the American Dietetic Association. 1979;74(3):331-6.
15. Price JH, Desmond SM, Ruppert ES, Stelzer CM. School nurses' perceptions of childhood obesity. Journal of School Health. 1987;57(8):332-6.
16. Puhl RM, Heuer CA. Obesity stigma: important considerations for public health. American journal of public health. 2010;100(6):1019-28.
17. Nemiary D, Shim R, Mattox G, Holden K. The relationship between obesity and depression among adolescents. Psychiatric annals. 2012;42(8):305-8.
18. Gortmaker SL, Must A, Perrin JM, Sobol AM, Dietz WH. Social and economic consequences of overweight in adolescence and young adulthood. New Engl J Medic. 1993;329(14):1008-12.
19. Karnehed N, Rasmussen F, Hemmingsson T, Tynelius P. Obesity and attained education: cohort study of more than 700,000 Swedish men. Obesity. 2006;14(8):1421-8.
20. Pearce MJ, Boergers J, Prinstein MJ. Adolescent obesity, overt and relational peer victimization, and romantic relationships. Obesity. 2002;10(5):386-93.
21. Sargent JD, Blanchflower DG. Obesity and stature in adolescence and earnings in young adulthood: analysis of a British birth cohort. Archives Pediatr Adolescent Medic. 1994;148(7):681-7.
22. Strauss RS, Pollack HA. Social marginalization of overweight children. Archives of Pediatr Adolescent Medic. 2003;157(8):746-52.
23. Viner RM, Haines MM, Taylor SJ, Head J, Booy R, Stansfeld S. Body mass, weight control behaviours, weight perception and emotional well-being in a multiethnic sample of early adolescents. Internat J Obesit. 2006;30(10):1514.
24. Neumark-Sztainer D, Falkner N, Story M, Perry C, Hannan PJ, Mulert S. Weight-teasing among adolescents: correlations with weight status and disordered eating behaviors. Internat J Obesit. 2002;26(1):123.

Cite this article as: Abdel Reheim NM, Ramadan Ali NG, Khot S, Vamegh M, Anwar M, Swilem M. Weight bias among health care providers for children in UAE. Int J Res Med Sci 2017;5:4697-700.