Obesity Bias in Primary Care Providers

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BACKGROUND AND OBJECTIVES: At the forefront of the obesity epidemic, obesity bias is an under-recognized and widely prevalent barrier to optimal care of the obese patient, even among primary care professionals. Recommendations for the reduction of obesity bias include increasing provider awareness about the complex etiology of obesity and the difficulties obtaining sustainable weight loss.

METHODS: Obesity bias was measured in primary care professionals (n=233) participating in a continuing education program, using the Anti-Fat Attitudes Questionnaire (AFAQ). Three sub-factors, “Fear of Fat,” “Willpower,” and “Dislike,” were evaluated. Participants were divided into three primary care experience groups: least experienced (0–9 years, n=67), moderately experienced (10–19 years, n=49), and most experienced (20+ years, n=98). “Fear of Fat” and “Willpower” components were found to be more prevalent than “Dislike”; however, scores on the “Dislike” subscale were highest and significantly more prevalent in the group with the most experience.

RESULTS: Results indicated that more experienced primary care professionals reported greater bias toward obese people than less experienced colleagues.

CONCLUSIONS: Ongoing continuing education that recognizes the wide prevalence of obesity, encourages respect for people of size, and mitigates obesity stigma should be promoted for all providers, particularly those who have been in practice for many years.

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Obesity is the foremost public health condition in the developed world. There are a number of barriers inherent in the management of obesity. One of the least recognized is the obesity bias that may exist in health care providers. According to a previous study, the prevalence of perceived weight discrimination among Americans has increased by 66% between 1995 and 2006. This bias has also been demonstrated in health care providers across all disciplines, including providers specializing in obesity management. Implicit and explicit stereotypes that fat people are lazy, stupid, and worthless are well known.

The impact of obesity bias could potentiality aggravate already poor physical and mental health outcomes found in the obese population. Research in obesity bias is relatively recent and scarce. The purpose of our study was to investigate the presence of obesity bias in Midwestern primary care providers and to determine if levels of bias differ based on length of practice.

Methods and Procedures
IRB approval was obtained from the Institutional Review Board (IRB # 10-15787). Study participants consisted of primary care health workers (n=233) enrolled in a continuing medical education (CME) program on obesity. The inter-professional sample included physicians, physician assistants, nurse practitioners, nurses, residents/students, pharmacists, dieticians, and physical therapists/exercise professionals. The overall group was 54.7% female.

Measure
Prior to the CME presentation, attendees indicated their level of primary health care experience: 0 to 9 years (n=67), 10–19 years (n=49), or 20 or more years (n=98). They completed Crandall’s 13-item Anti-Fat Attitudes Questionnaire (AFAQ), designed to assess explicit anti-fat prejudice. The AFAQ consists of three subscales, “Dislike,” “Fear of Fat,” and “Willpower.” The “Dislike” subscale assesses an individual’s...
explicit antipathy toward fat people (eg, “I don’t like fat people much”). The “Fear of Fat” subscale assesses personal concerns and distress about weight or the prospect of becoming overweight (eg, “I feel disgusted with myself when I gain weight”). The “Willpower” subscale assesses the belief that being overweight is a matter of personal control or lack thereof (eg, “Fat people tend to be fat pretty much through their own fault”). Items are scored on a 10-point Likert scale (0=very strongly disagree, 9=very strongly agree), with higher scores indicating greater anti-fat bias. An average score was obtained for each subscale, and differences across levels of experience were examined.

Results
On average, across all providers, respondents scored significantly higher on the “Fear of Fat” subscale (M=5.1, SD=2.4) and the “Willpower” subscale (M=4.9, SD=2.1) than on the “Dislike” subscale (M=2.1, SD=1.7; F=192.7, P<.001). No significant differences were found among the least, middle, and most experienced groups on these subscales.

Univariate analyses of variance (ANOVA) examined differences on each of the AFAQ subscales among the three levels of primary care experience. Significant differences were found among experience levels for the “Dislike” subscale. Post hoc analyses using Tukey’s HSD test indicated that primary care professionals with 20 or more years of experience expressed greater dislike than primary care professionals with less than 10 years of experience. Those with 10–20 years of experience did not differ significantly from either the least or most experienced groups (Table 1).

Discussion
This study extended previous research on the AFAQ to a Midwest primary care provider sample. Based on the significantly higher scores noted in the “Fear of Fat” subscale and the “Willpower” subscale, attribution misconceptions about obesity in their patients as well as their own weight status is prevalent. However, overall significant dislike of obese people was absent. Crandall et al describe the attribution-value model of prejudice in which they hypothesize that prejudice comes from negative stereotypical behaviors in a particular group. Ratings on the “Willpower” subscale were high, reflecting the belief that being overweight is due to a personal lack of control in maintaining a healthy weight. Interestingly, the respondents scored higher on the “Fear of Fat” subscale, suggesting that some were self-critical about their own weight gain and held a fear of becoming overweight (Table 2).

The fundamental attribution error states that we account for others’ actions and behaviors based on stable and consistent traits, while we see our own behaviors and actions as due primarily to current circumstances. This may explain the higher scores for “Fear of Fat” and “Willpower.” Thus, negative attribution of “Willpower” in others and “Fear of Fat” in themselves lead to higher scores on these two scales as opposed to the “Dislike” subscale.

Further, primary care professionals with 20 years or more experience expressed greater anti-fat bias in the form of greater explicit antipathy (“Dislike”) toward obese people than their less experienced primary care colleagues. This finding was not found for the “Fear of Fat” and “Willpower” subscales. Similar findings have been reported in a French population. It is possible that more experienced US primary care professionals may not be aware of recent complex models of obesity and its etiology. Additional education for this population may reduce their anti-fat bias.

There were several limitations to this study. It was a cross-sectional design with a survey that was administered before an educational session on obesity. The sample displayed an interest in learning more about obese patients, which may have impacted their responses to the survey; in addition, change in bias before and after the session was not assessed. Future research should study this stigma across the entire career. Data were not collected regarding the providers’ body mass indexes (BMIs) or whether they have personally and successfully managed their own weight. Physicians who successfully manage their own weight have less bias.

| Table 1: Means and Standard Deviations (SDs) on Anti-Fat Attitudes Questionnaire (AFAQ) Subscales |
|-------------------------------------------------|-----------------|-----------------|-----------------|--------|---------|
| Anti-Fat Attitudes Questionnaire* Subscale      | Level of Practice Experience | Less Than 10 Years | 10–20 Years | 20+ Years |
| Dislike                                        | M (SD)           | M (SD)           | M (SD)       | F      | Sig.    |
| Fear of Fat                                    | 1.5 (1.5)        | 2.1 (1.5)        | 2.3 (1.7)    | 4.2    | 0.016   |
| Willpower                                      | 5.0 (2.0)        | 5.1 (2.3)        | 4.6 (2.1)    | .90    | 0.407   |

* Likert-type response scale (1=very strongly disagree, 10=very strongly agree); higher scores indicate stronger antifat attitudes.
Conclusions
The effects of obesity bias are important to understand in today’s health care system. While the current results reveal significant prevalence, they suggest that the bias does not lead to an overall dislike of obese patients. We infer that targeted educational programs should be constructed that specifically address the factors that lead to obesity bias and mitigate them. Addressing these factors early on may result in better understanding of how to provide medical care to obese patients. It should be our goal as health care providers to see each patient as an individual and to address their unique health needs rather than allowing our previous patient experiences or self-experiences to guide our beliefs, associations, and attitudes regarding obesity.

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