Exploring Medical Professionals Experiences and Perceptions of Shaming and Stigmatisation in Patients that are Overweight/Obese.

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Declaration

I declare that this thesis that I have submitted to Dublin Business School for the award of Higher Diploma in Psychology is the result of my own investigations, except where otherwise stated, where it is clearly acknowledged by references. Furthermore, this work has not been submitted for any other degree.

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Abstract

Obesity levels are increasing at an alarming rate and presents tremendous threat to the general population. Being overweight or obese can have multiple negative psychological consequences on well-being and health. The development of weight stigmatisation and shaming amongst healthcare professionals is also growing at a significant rate and can contribute to the negative psychological impact. Through research it has been found that healthcare professionals' inertia to engage with individuals who are overweight or obese is related to the increasing levels of obesity. The aim of this qualitative study was to investigate the healthcare professional's experiences and perceptions of stigmatisation and shaming of individuals who are overweight/obese. Various themes emerged from the interviews such as the anti-fat attitudes from healthcare professionals and potential strategies to reduce stigmatisation. Overall, healthcare providers aim to provide the highest level of healthcare to all and to tackle the rate obesity must reduce their levels of patient stigmatisation.

2. Introduction

2.1 Description of the Issue of Obesity

One of the biggest public health burdens globally is the increasing levels of overweight and obese individuals. According to the European Association for the Study of Obesity (EASO, 2019) obesity is ranked as the 5th leading risk factor for global deaths, with annual mortality rates at 2.8 million adults as a result of being overweight or obese. In Western society the rate of overweight and obese individuals is growing at an alarming amount. According to the World Health Organisation (WHO, 2019) since 1975 the worlds frequency of obesity has nearly tripled.

In Ireland, the Central Statistics Office (CSO, 2019) reports that in 2015 the percentage of individuals who were classified as overweight or obese stood at 60%, and significantly, this rate rose to 62% in 2017. If this trend continues Ireland is on course to become the most obese country in the EU. The World Health Organisation (WHO, 2019) states that being overweight and obese is defined as abnormal or excessive fat accumulation that may impair health. It has been shown that individuals who are overweight or obese often suffer from obesity related co-morbidities such as, issues with the cardiovascular system, hypertension, hypercholesterolaemia, type II diabetes, myocardial infarction, angina and stroke (WHO, 2000).

Consequently, healthcare professionals are coming into contact with individuals who are deemed to be overweight or obese more often due to the various co-morbidities linked with obesity. It has been suggested that healthcare professionals have an integral responsibility for directing the future management of obesity; this is supported by research carried out by Tham & Young (2008) that states, Dietitians, Nutritionists, Personal Trainers and General Practitioners in particular are acknowledged by individuals as having an imperative role in

weight management. Nevertheless, individuals who are overweight and obese are subjected to prejudice and bias as a consequence of their weight. Research by Puhl & Brownell (2012) exclaims how obesity is a highly stigmatized condition associated with blame. However, this is not a new phenomenon, studies dating back to the early 2000's alarmingly suggest that blame is often perceived by the patient when speaking with a healthcare professional regarding their weight (Teachman & Brownell, 2001 and Harvey, Summerbell, Kirk et al., 2002 as cited in Swift et al., 2013). Collectively, healthcare professionals and the general population need to work cohesively, to reduce the issue of obesity in Ireland.

Healthcare professionals who portray a negative attitude may project or influence patient behaviour, which can have a serious outcome for the clinical treatment of obesity; including the avoidance of the utilisation of healthcare services (Puhl & Brownell, 2001). In general, these negative attitudes towards individuals who are overweight or obese aid the development of weight bias (Throsby, 2007). This can be translated into discrimination in various settings such as in employment and education. Research by Puhl & Heuer (2009) states that often due to extensive negative stereotypes individuals who are overweight and obese are classified as "*lazy, unmotivated, lacking in self-discipline, less competent, noncompliant, and sloppy*". As a result of their study, it generated stereotypes from various settings creating a narrative that develops into weight bias, weight stigma, and weight prejudice which can be used interchangeably to refer to adverse attitudes and judgement toward individuals based on their body weight. Shaming, stigmatisation and bias regarding weight has increased as overweight/obesity becomes more prevalent.

There are multiple studies (Owen-Smith, Donovan, & Coast, 2014, Tomiyama et al., 2018) that highlight healthcare professional's anti-fat attitudes. These harmful attitudes displayed by various healthcare professionals could possibly affect clinical judgments and discourage individuals from seeking care regarding their weight. This is in turn has a

detrimental impact on the resources of the government; It is stated by the Health Service Executive (HSE, 2018) that in 2009, in Ireland, the cost of adult obesity was conservatively estimated to be €1.13 billion, with direct healthcare costs of €450m. Therefore, the aim of this study is to investigate the experiences and perceptions of health care professionals working at a primary healthcare level, such as GP's to combat weight concerns.

2.2 Current Status of Obesity

In Ireland, there has been an unprecedented rise in the levels of overweight and obese individuals and is set to top the European league table for obesity by 2030 (World Health Organisation, 2019). Arora, Barquera, Farpour, Lambert, et al., (2019) state that the inertia in addressing the issue of obesity can be attributed to the predominant and persistent reasoning that obesity is matter of personal responsibility. Admittedly, in reality obesity is deeply-rooted in a complex interconnection of genetics, physiological, psychosocial, and environmental factors; these collectively, require a multisystem-level action (Brewis, SturtzSreetharan, & Wutich, 2018). Throughout the world, there is a cultural understanding of obesity as a moral failure that leads to impaired health and quality of life.

The HSE, (2018) and Arora et al., (2019) describes obesity as being when an individual is carrying excessive adiposity in relation to their height and sex. Usually, a person is classified as overweight when their Body Mass Index (BMI) is within the range of 25-29.9, the classification of obesity is when an individual's BMI is greater than 30 and those defined as morbidly obese are greater than 40. According to the Arora et al., (2019), BMI is only a substitute marker of adiposity. BMI tends to be used for screening and population measurement and does not consider muscle mass of an individual. Therefore, a sole focus on BMI tends to exacerbate the misunderstanding and stigma that exists within the current description.

At an individual level, research states that those who are overweight or obese tend to be portrayed as less physically attractive, undisciplined and greedy individuals who should be ashamed of themselves (Brown-Bowers, Ward, & Cormier, 2017). People who are overweight are often regarded as being lazy and having a weak character (Throsby, 2007). Throsby's (2007) research additionally states that the burden also exists in the form of a moral imperative on the individual to treat and take preventive action against obesity.

Obesity is recognised as a chronic disease. Furthermore, the obesity trend will likely continue for decades to come and therefore, fuelling the global obesity epidemic. If this trend of worsening population health continues, it creates challenges to infrastructure as countries attempt to meet the additional health-care demands, and greatly increasing health-care expenditures world-wide. As previously mentioned, obesity related health issues in Ireland have estimated costs to the exchequer of €1.13 billion (HSE, 2018). Weight management must be tackled dually from not only a top down approach but a bottom up approach. The individuals must be willing to engage in a behaviour change and be assessed by The Transtheoretical Model by Prochaska and DiClemente (1983). Nevertheless, individuals who have weight management issues have often expressed concern; obesity is a stigmatised condition therefore, individuals have often felt alienated or humiliated due to their body image. Therefore, obesity needs to be tackled beyond an individual's weight management level; but at a societal and economical level. Innovative strategies will be necessary to prevent further increases in overweight and obesity rates.

In 2005, the Irish Government established The National Task Force on Obesity to combat the growing phenomenon. Obesity does not just happen overnight; the issue develops gradually due to poor diet and lifestyle choices. However, research states that a person may be predisposed to weight gain through their genes; this is supported by research by Ring (2019) who states that children of women who are overweight or obese are at a higher risk of becoming

obese themselves and more likely to develop diabetes and heart disease. Ring (2019) additionally cited reports that were published in The Journal of Physiology which have shown that the effects of maternal obesity even pass across generations to offspring. Statistically, in Ireland, there is estimated to be 300,000 children living with weight concerns.

In Western societies the social norm for individuals is to be slim (Owen-Smith et al., 2014), and research states that those who suffer from weight issues are continuously confronted with this social norm (Malterud & Ulriksen, 2010). Furthermore, society's rhetoric of the description of obesity can be stigmatising. Grønning, Scambler, & Tjora, (2013) outline that terminology such as "obesity epidemic', 'the fight against obesity' and 'the war on the obesity epidemic' can increase the stigmatisation and shame and indicate that obesity is viewed as a medical, financial and social liability in society (Brown-Bowers et al., 2017).

Nevertheless, there are a wide range of reasons that contribute greatly to the levels of obesity. Wadden, Webb, Moran, & Bailer, (2012) and Cook & Gazmararian, (2018) state that long working hours contribute greatly by reducing time for physical activity, particularly for individuals working in sedentary occupations. Cook & Gazmararian, (2018) study interestingly revealed that individuals who hold a higher status position in employment and come from higher socioeconomic status (SES) tend to engage in more sedentary behaviour compared to those working in lower status positions who report more occupational activity. Yet, in contrast it is widely known that those who come from a lower SES have limited access to healthy nutritious foods (Templin, Hashiguchi, Thomson, Dieleman, & Bendavid, 2019).

2.3 Healthcare Experiences & Perceptions of Obesity

As previously stated, individuals who are overweight or obese may suffer from secondary comorbidities such as diabetes, hypertension, cardiovascular issues and many more. Therefore, this means that these individuals will rely on the medical services significantly

more. In a study by Ranjan, Kumari, & Chakrawarty, (2015), it is noted that there are basic principles involved when communicating effectively with patients. These principles include: patient listening, empathy, and paying attention to the paraverbal and nonverbal components. Research has shown that good communication skills in a medical professional can improve patient's compliance and overall satisfaction with behaviour change. However, occasionally there is a lack of these principles, which results in a breakdown in communication, leading to shame or blame being placed upon the patient. Research carried out by Ranjan et al., (2015) further notes that there is an unfortunately high rate of stigmatisation of individuals with overweight and obesity existing in healthcare; with patients stating that they perceived negative attitudes from medical professionals such as nurses and doctors. Patients have stated that they have received insensitive comments and gestures, and felt they were being treated as "charts" or "obese women", rather than individuals. Some felt nurses showed disrespect by not listening to them, or by not believing or acknowledging their stress about weight loss.

In 2017, research that was conducted by Pervez & Ramonaledi (2017) cite the Royal College of Nursing (2012) as stating that engagement of medical staff such as nurses, General Practitioners, Nutritionist and Dieticians and many more all collectively play an essential role in preventing and managing levels of obesity. A study by the National Health Service (NHS,2019) revealed that there is an increasing number of individuals with a primary diagnosis of obesity being admitted to general hospital wards due to co-morbidities caused by obesity. Poon & Tarrent (2009) state that negative attitudes towards obese patients are likely to reduce the quality of the care they receive, and nurses have a duty to provide compassionate, dignified and non-judgemental care.

Primary care clinicians inclusive of GP's and nurses have been assigned a key role in the prevention and treatment of excess weight and obesity (Blackburn, Stathi, Keogh, & Eccleston, 2015). Through their research it is evident from patient surveys that less than half

of obese patients are advised by their physician to lose weight. This is supported by Tham & Young (2008) who revealed that although viewed as gatekeepers for access to medical services to help with weight management, GP's rarely address this in their consultations. GP's are ideally positioned to manage obesity as they are the point of contact before referral to additional services. Tham & Young's (2008) research aimed to explore reasons why engagement between the patient and the GP was low when dealing with weight management and furthermore, addressed the perception of the role of the GP in managing their weight. Within their research they state that annually, approximately 80% of the Australian population consult their GP for health issues, yet, 60% of the population is classified as being overweight or obese; therefore, the question remains why is the issue of weight management not discussed at the primary contact of the GP. As stated previously, there is limited research that addresses this issue and Tham & Young's (2008) research supports that statement.

Tham & Youngs (2008) quantitative research consisted of 367 participants (n=143 females and n=124 males) aged between 18 and 64 years. Their findings revealed that over 70% of the participants of the study believed that a GP plays a significant role in the management of their weight; yet, 74% of the engaging participants stated that they would be hesitant in bringing up their weight to their GP. Some of the participants of the study are cited in saying that GP's *"are too busy with other medical issues to be burdened with weight and do not have enough time in consult about weight management*". Other participants of the study who had co-morbidities due to weight issues were more likely to engage with the GP about weight management. Furthermore, the startling result that Tham & Young's (2008) research revealed was that the participants of the study believed a personal trainer was the most equipped to deal with issues of weight management, with the participants ranking GP's at the 4th most likely to be approached to help with weight management. The participants revealed that GP's approach to weight management can often by one of judgement or lack of interest, resulting in

the patient not engaging with them about the issue. Furthermore, this study indicated that GP's are somewhat reluctant to bring up a client's weight during consultations unless the consultation is associated with related illness, which supports the findings that GP's can often not be interested in tackling the issue of obesity. Therefore, there needs to be an urgent discussion on how to improve the standards of obesity management at primary care level.

It cannot be said that only GP's have an issue with combating the issue of obesity; according to research done by Pervez & Ramonaledi (2017) they found nursing staff hold negative views of patients who are overweight or obese, as already mentioned. The study outlines a number of factors that contribute to the attitudes of nurses. These include: the perception and interactions with the patient, lack of comprehensive knowledge of obesity; and challenging workloads in care settings with a high number of obese patients. Pervez & Ramonaledi (2017) cite Brown et al.'s, (2007) investigation into the perceptions and interactions of nurses towards obese patients. Brown et al., (2007) revealed that although rare, complete negative stereotypes, negative attitudes and beliefs were openly expressed. Results revealed that 68.9% of nurses viewed obesity as a result of poor personal food choices and low engagement levels of physical activity. Furthermore, perceiving and describing obese patients as, "*greedy*", "*and indulging*". The study additionally reports that the nursing participants believed that 54.7% of these patients had low or no willpower, motivation or strong personality to change their lifestyles. These thoughts and opinions are presented as barriers to discussing effective weight loss strategies to support and enable the patient in making effective and positive life choices. Supporting research which displays negative attitudes of medical professionals at a foundation level can be seen in research by Keyworth et al., (2013). Their study consisted of qualitative interviews of 20 undergraduate nursing students. They were exploring their perceptions and beliefs towards problematic weight. The participants of the study exposed that they witnessed qualified and senior nursing staff display negative attitudes

towards patients who are obese; the participants stating that these senior nurses would "mock, judge, discriminate and ridicule against" these patients. And as a result, this would set a bad example to the student nurses, potentially encouraging them to be demeaning and judgmental, instead of showing respect and working in partnership with patients.

A study by Swift, Tischler, Markham et al., (2013) investigated how the use of anti-stigma films would reduce weight bias among trainee healthcare professionals. The study aimed to reduce trainee dietitian's and doctor's attitudes towards weight stigmatisation for patients who were classified as obese. This study cited National Institute for Health and Clinical Excellence (NICE, 2006) as stating that trainee doctors, dieticians and various other healthcare professionals will be vital to the multidisciplinary approach in targeting the future management of obesity, therefore, healthcare professionals must be willing and able to engage empathically with individuals who are overweight and obese. The study consisted of nineteen 4th year registered dietetic students and twenty-four 3rd year registered medical students, with a pre and post experimental design with a 6-week follow-up. The study consisted of an intervention group (n = 22) and a control group (n = 21). The study revealed significant weight bias among participants at baseline as well as strong beliefs that obesity is under a person's control. Swift et al., (2013) further note that recognised interventions that combine a multiple attitude-change strategy may be required to tackle the complexities of obesity stigma and translate into less biased behaviour from healthcare professionals.

2.4 Training for Healthcare Professionals to target Obesity

According to Sanchez-Ramirez, Long, Mowat, & Hein, (2018) obesity by nature is complex and multifactorial. This is largely associated with healthcare providers feeling overwhelmed and ineffective in their ability to influence this ever-increasing epidemic. Furthermore, healthcare professionals are often ambiguous and avoidant because they are

uncomfortable about discussing overweight and obesity with their patients. Sanchez-Ramirez et al., (2018) additionally, notes that some healthcare providers view obesity as more of a public health matter. It is stated that medical practitioners have identified various challenges for example, lack of knowledge and training in the treatment of obesity. This is mainly due to not having enough resources such as, current assessment and counselling strategies, and behaviour management to deal with this issue. Godley & Russell- Mayhew (2010) found that an interprofessional approach can improve obesity outcomes. This means an encouraging multidisciplinary team who work cooperatively to provide comprehensive care.

2.5 Shame and Stigmatisation of Obesity

Shame, it is a recognised as being a powerful force in a clinical encounter. Dolezal & Lyons (2017), state that shame is under-acknowledged, under-researched and under-theorised within the framework of health and medicine. Darby, Henniger, & Harris (2014) note that although shame can be a frequent occurrence within healthcare settings, there is a significant lack of research which examines the effect of shame and other negative self-conscious emotions. Shame is acknowledged as a negative emotion; it arises when an individual is viewed or judged by others. Dolezal and Lyons (2017) further note that, shame can bring a wide range of negative self-conscious experiences; for instance, embarrassment, humiliation, mortification and a feeling of defectiveness or low self-worth.

According to multiple research studies stigma regarding an individual's body weight has spread and deepened globally (Andreyeva, Puhl & Brownell,2008; Brewis, Wutich, Falletta-Cowden & Rodriguez-Soto, 2011). Tomiyama, Carr, Granberg et al., (2018) state that weight stigma is defined as the social rejection and devaluation that occurs to those who do not comply with prevailing social norms of adequate body weight and shape. Terminology such as, weight bias, weight stigma, and weight prejudice can be used interchangeably to refer to

adverse attitudes and judgement toward individuals based on their body weight. Tomiyama et al., (2018) shows that weight stigma is pervasive, and women are particularly stigmatised regarding their weight across multiple sectors, including employment, education, media, intimate relationships and many more. Research by Phelan, Dovidio, Puhl et al., (2014) found that weight stigma was significantly pervasive in healthcare settings.

There is a substantial body of literature that can contribute to theoretical and empirical work relevant to stigma, weight and its connection to the attitudes of healthcare staff. Phelan, Link, & Dovidio, (2008) state that there are many definitions of stigma which all highlight the numerous stigmatised characteristics. Setchell, (2017) cite research by Crocker, Major and Steele (1998) who devised a widely used definition "*stigmatized individuals possess (or are believed to possess) some attribute, or characteristic, that conveys a social identity that is devalued in a particular social context*" (p. 505). This definition of stigma outlines that it is not a static phenomenon but is created in various contexts and greatly involves negative judgement such as, being devalued. Lastly, stigma coveys a social identity rather than an individual. Understanding stigma as a product of social interaction rather than something that resides within the stigmatised individual, can be useful when investigating how weight stigma develops through interactions with healthcare professionals and the patient. Link & Phelan, (2006) outline that much of the thinking around stigma has come from the influential work of Canadian sociologist Erving Goffman. Goffman believed that stigma was socially produced. Link & Phelan (2006) cite Goffman's (1963) research where he describes stigma as an attribute that is deeply discrediting. Link & Phelan's (2006) research outline that these assumptions can contribute to the development of stereotypes and discrimination that, at times dramatically limit the life expectancy or health outcomes of the stigmatised person.

Classifying someone as overweight is never a neutral endeavour. The word obese is found to evoke negative evaluations rather than being called fat (Vartanian, 2010). Yet, a study

by Brochu and Esses (2011) indicated that the term fat sparks more negativity than overweight. Currently, in a medical context fat is not a commonly used term. Words such as obesity, bariatric and overweight are the most preferred in medical discourses. Weight stigma refers to the stigmatisation of a person who is seen as overweight or fat (Allison & Lee, 2015). Research by Puhl & Heuer, (2010) claim that weight stigma produces stereotypes such as laziness, sloppiness, lack of intelligence, unattractiveness and lack of self-discipline. In a health context, another aspect of these stereotypes is perceived lack of compliance with healthcare behaviours (Puhl & Heuer, 2009). Weight stigma tends to drive the obesity epidemic and harms health (Tomiyama et al., 2018).

Weight stigma has been reported across multiple sections of healthcare. Numerous studies highlight that various healthcare professions such as, nurses, rehabilitation personal trainers and dieticians are all guilty of engaging in weight stigma (Mulherin, Miller, Barlow, Diedrichs, & Thompson, 2013; Poon & Tarrant, 2009; Wise, Harris, & Olver, 2014 & Stone & Werner, 2012). A study by Harvey & Hill, (2001) indicates that clinical psychologists working as part of a multidisciplinary team specialising in obesity management have also demonstrated weight stigma. It is noted that the healthcare system was generally unsupportive of individuals living with obesity. Furthermore, that the medical narratives construct obesity as a disease and an epidemic tend to have generated greater weight stigma.

It is commonly suggested that stigmatisation of individuals who are overweight or obese is achieved by applying social pressure that may incite weight loss. Setchell, (2017) cite Ogden, (2013) as stating that weight stigma has often been thought to have a positive effect by motivating weight loss behaviours. Although this belief is not widely accepted in academic or scientific discourse, public health campaigns frequently use weight stigma to promote weight loss (Abu-Odeh, 2014). The stigma associated with obesity has major psychological and socioeconomic burdens on the individual, healthcare providers and society. Tomiyama et al.,

(2018) study highlights that weight stigma has been linked to the trigger of physiological and behavioural changes in people who are classified as morbidly obese. This is largely associated with co-morbidities such as poor metabolic health, increased weight gain and mental health deterioration which for some are motivating factors to change. Weight stigma is closely linked with profound negative mental health problems. This is linked with negative view upon their body image. According to Harriger & Thompson, (2012) body image is defined as an individual's subjective evaluation of his/her own appearance. Body dissatisfaction is common in individuals who are overweight or obese and it strongly linked to mental health issues such as, low self-esteem and depression.

Yet, in contrast, a study by Puhl and Heuer (2010) suggests that using weight stigma to motivate weight loss has consistently been shown to be ineffective. Sutin et al., (2016) outline that individuals who experience weight discrimination and stigmatisation tend to participate in more health-risk behaviours. Furthermore, Sutin & Terracciano, (2013) reported that weight stigma may reduce the ability of treatment-seeking adults to complete weight loss measures due to the lack of interest displayed by healthcare professionals. Research by Gudzune, Bennett, Cooper, & Bleich, (2014) found that in a survey of 600 adults, it was discovered that patients who feel judged about their weight have lower trust in their primary healthcare providers. Additionally, Drury & Louis, (2002) state that people avoid healthcare appointments for fear of weight stigma. Healthcare is a setting in which weight stigma is particularly pervasive. Brewis (2014) highlight that a pervasive environment of stigma might reinforce or promote weight gain through negative feedback from the healthcare professional. Tomiyama, Flinch, Belsky et al., (2001) cited by Tomiyama et al, (2018) indicate that observations of clinicians specialising in the area of obesity found high levels of weight bias, with a proportion of these clinicians stating explicit ‘anti-fat’ bias sentiments such as ‘Fat people are worthless’.

Other research which suggest that weight stigma is often used to motivate weight loss is ineffective, as shown by Houston (2019). It found that Cancer Research UK launched a health promotion campaign which aimed to highlight the link between obesity and cancer. Through their campaign they advertised the fact that both smoking, and obesity are risk factors for cancer. However, once the campaign was launched accusations of fat shaming ensued. The campaign was criticised for proposing that obesity caused cancer. Whereby, correlation and not causation, was the true relationship. Kersbergen & Robinson, (2019) suggest that indirect dehumanisation has been thought to facilitate prejudice and people with obesity are not only stigmatised but are blatantly dehumanised. A recently developed social psychology concept, blatant dehumanisation, explains the overt communicated belief that one individual is less human than another (Kteily, Bruneau, Waytz, & Cotterill, 2015).

2.6 Purpose of current study

Despite growing literature on weight stigmatisation and shame in the context of healthcare professionals globally, little work has been done on weight stigma in an Irish context. As previously stated, Ireland is on course to become the leading country in the EU for obesity. The above literature indicates that overweight or obese individuals often avoid accessing healthcare due to the system being inadequately set up to meet their needs such as unsuitable equipment but mainly due to anti-fat attitudes held by providers. These perceived barriers prevent individuals with weight issues from accessing services and receiving appropriate healthcare. Additionally, the most common reason cited in the literature on the avoidance of healthcare by overweight or obese individuals is shame. Therefore, if this issue is to be tackled it must come from a grass roots level rather than dealing with its vast health consequences. This research wants to understand healthcare professional's experiences and perceptions of shaming and stigmatisation in patients that are overweight/obese. This study aims to expand on existing knowledge in the field of psychology on the subject of

stigmatisation and shame, which at present is an under-researched area in an Irish context as well as bridge the gap in the literature such as investigating the opinions of Irish healthcare providers, the impact stigma and shame has on patients and the access to services.

The research questions for the present study include:

RQ1: What are the healthcare professional's experiences of working with individuals who are overweight or obese.

RQ2: What are their perceptions towards stigmatisation and shame towards patients with weight issues?

RQ3: Have they been guilty of blaming their patients for weight issues?

3. Methodology

3.1 Participants

The study population included Healthcare Professionals who work on the frontline with cliental who are overweight/obese. The criteria for this study included that the participants must be Healthcare professionals dealing with the specific population (cliental that are overweight/obese).

The participants were recruited for this study through the combination of convenience and snowball sampling. Convenience sampling was the chosen method as the researcher had close proximity and developed a rapport with two of the participants. These participants also provided snowball sampling opportunities to the researcher. Although snowball sampling is not a measurement tool itself, it played a vital role in this study as the two participants were recruited via the other participants.

A total of four Healthcare Professionals were interviewed; a General Practitioner, a Personal Trainer, a Nurse and a Dietician. There was a gender balance of two males and two females and with the age range between 28 years and 45 years. There were no monetary incentives used for any of the participants, however, the researcher did provide a thank you card and a small gift for providing their time to engage in the study.

3.2 Research Design

The research conducted was undertaken by completing four separate qualitative interviews. Interviews are usually in-depth and semi-structured with the use of a semi-structured interview guide; the researcher developed a semi-structured interview guide which can viewed in appendix B. This guide aided the development of the interview but also allowed for further questions through emerging information provided by the interviewees. The aim for each interview was for the researcher to obtain essential information that addressed the proposed research questions and furthermore, gain invaluable information and knowledge from the engaging participants.

These interviews allowed for rich in-depth conversations in a safe and secure manner and environment. The inductive approach allowed for the researcher to begin this study with an open mind without any preconceived ideas with the aim to generate a new theory from the

emerging data. Interviews provide an effective and safe manner to conduct interviews with participants. Interviews provide a relaxed natural environment where participants can confidently discuss their experiences and perceptions of the status of obesity in Ireland, perceived patient blame and stigmatisation, the potential impact of blame and stigmatisation could have on the patient and what can be done to overcome not only the stigma but the issue of obesity.

3.3 Materials and Apparatus

Aforementioned, the researcher of this study used a semi structured interview schedule to aid and direct each interview. Moreover, the schedule allowed for further questions to be probed as the interviewees provided rich information that required expansion. The semi structured interview schedule was primarily developed by the researcher and through supporting research identified in the literature review. The semi-structured schedule can be seen in the appendix 1.

All four interviews took place between December 2019 and January 2020 at various venues to suit the interviewees. The duration of each interview was approximately 40-50 minutes and each interview was recorded on a Dictaphone that is privately owned by the researcher to ensure maximum confidentially. Each interview was transcribed verbatim and then entered into NVivo 12, the data management programme.

Additional apparatus comes in the form of the researcher's private laptop.

3.4 Procedure

Initially, the researcher contacted each participant via email and provided them with the information sheet that outlines the purpose of this study and also the option to decline in partaking further.

As previously mentioned, each participant was provided with an information sheet (*appendix C*) and before interviews commenced, the participants signed consent forms (appendix A). Once the participant agreed to partake, a suitable time and location was mutually agreed between the researcher and the participant. Each of the four interviews that were conducted in a different location that best suited the interviewees however, each interview had the same structure.

Once the researcher met with the participants, she thanked them for agreeing to partake. The researcher then informed the interviewee that the remainder of the conversation was going to be recorded on the Dictaphone. Once recording commenced the researcher introduced the participant and outlined the various confidentially components of the study; The researcher then provided them with a consent form that outlined the purpose of the study. By the participants signing the consent form it secured the information that they provided.

Each interview lasted approximately 40-50minutes in duration and the researcher used the semi-structured interview guide to aid the conversation. The researcher then thanked the participants before ending the interviews.

3.5 Data Analysis

The qualitative data obtained via the interviews were analysed using Braun and Clarkes Thematic Content Analysis; according to Saks & Allsop (2007) they describe thematic content analysis as a rigorous, systematic, flexible and accessible technique to analysis data. It identifies, analyses and reports on patterns and themes that emerge from the data.

Thematic analysis is a 6-phase guide to performing analysis of data; the method identifies, analyses and reports patterns/themes within data.

These 6 steps include:

1. Familiarise yourself with the data
2. Create initial codes
3. Search for themes
4. Review these themes and refine themes
5. Define these themes and name themes
6. Produce a report on the themes supporting them with quotes

Each interview was transcribed verbatim and entered into the data management programme Nvivo 12. To ensure maximum results each transcript was analysed multiple times.

3.6 Ethical Considerations

Before commencing this study, the researcher submitted a research and ethics proposal from to obtain authorisation for Dublin Business School. Once granted the researcher was able to meet with the assigned research dissertation supervisor to address any issues before any interviews took place.

It was essential before any interview was conducted that the researcher informed all the participants of the purpose of the study and furthermore, obtained consent from each participant to conduct the interviews. Prior to the interviews been conducted the researcher provided an information sheet that outlined the purpose of the study and addressed any confidentially issues regarding the participants such as names and storage of obtained data. Data is stored on the researcher's private laptop and has encrypted access codes. The laptop stores the audio files and transcripts. This data needs to be retained for storage over the next five years including the consent forms, all raw data (interview transcripts) and any data that was coded during the analysis. Due to GDPR restrictions, for long-term storage all data needs to be saved electronically, including consent forms; therefore, these will be scanned and saved. At this point the researcher will encrypt all data in order that it can be transferred securely. Furthermore, the laptop has update anti-virus software.

As the research dealt with topics of a sensitive nature, such as, patient shame or patient blaming the researcher was aware that potential defensive approaches may be highlighted during an interview and was therefore, aware not to provoke any potential insult or accusation towards the healthcare professional. As the research study is looking at their perceptions and experiences there was no known direct harm caused to the participants.

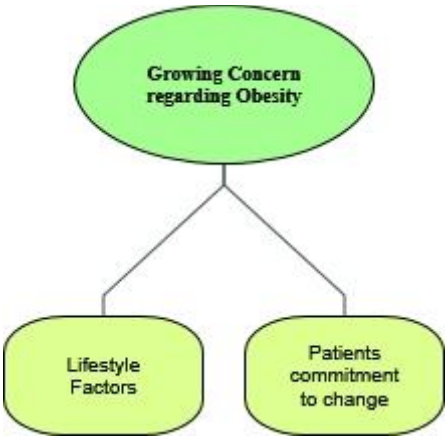
4.Results

4.1 Thematic Analysis

The researcher of this study was familiarised with the data from the interviews by transcribing and reading through the interview responses. The interviews were transcribed verbatim and then processed on NVivo 12. Braun and Clarke (2006) describe the transcription process as the most important in thematic analysis because it allows for close attention to the data, interpretation and analysis. When transcription of the interviews was completed, initial codes were created using the entire data set of interviews and content that related to experiences and perceptions of healthcare professionals of shaming and stigmatisation in patients that are overweight/obese.

The data was categorised into four themes from the coded content on NVivo 12. Any sub-themes were created based on their relationship to the main theme. Themes were re-examined to establish if the theme was suitable to the coded data. From this, clear labels and definitions were given to each theme and sub-theme. Lastly, a report was developed of each theme which aimed to address the proposed research questions and previous research on stigmatisation and shame of patients who are overweight/obese. A mind map was produced to give a clear picture of healthcare professional's stigmatisation and shame of patients who are overweight/obese.

4.2 Theme 1: Growing Concern regarding Obesity.



Obesity is one of the fastest growing modern-day epidemics. As previously mentioned, Ireland is on course to becoming leaders on the league table for obesity by 2030. A quote from the GP highlights that his is a growing concern he has seen throughout his career.

"people are getting fatter there's no doubt about it and the number of people coming through the door that are overweight or obese compared to when I would have seen... say 15 years ago it increases...it increases every as every few years"

There are many factors that affect the levels of obesity such as lifestyle factors. Access to healthy and nutritious foods can often be perceived as difficult and emerging data from this study highlighted that often obesity can be largely associated with poorer socioeconomic communities.

"that slightly better off people middle class people and beyond and above that will have ehm what do you call it... enjoy better health and less likely to be overweight" (GP)
"you've the population going in 2 directions … I think the worry in the future maybe in another 10 to 15 years is that obesity, smoking, cardiovascular disease, diabetes will be largely poor folk" (GP)

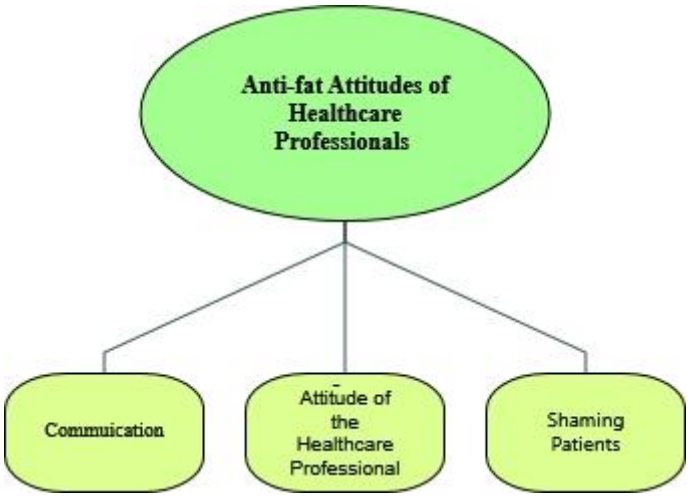
Table 1: Quotes that support that obesity is linked with poorer socioeconomic communities.

Achieving and maintaining changes in lifestyle behaviour is a complex process. It encompasses an individual's motivation and readiness to change, which involve working coherently with healthcare providers.

"*I've had people come into me who are classified as morbidly obese who have lost 5/6 stone and have really worked hard and then I've had people who've been the same weight come into me and after a week I've never seen them again." (Personal Trainer)*
"…from the beginning say like why are you here today you know what do you want to achieve and you know like nearly say we've got a scale of 1-5 for like motivation where are you at right now you could spend a whole consultation just trying to find out someone's kind of like motivation for something even when you get into anything related to food at all." (Dietician)

Table 2: illustrates selected quotes that shows the complexity of willingness to change.

4.3 Theme 2: Anti fat attitudes of Healthcare Professional's.



Anti-fat attitudes held by providers present yet another barrier for overweight individuals in accessing appropriate healthcare. "*your case load has to be prioritised and those patients don't actually fall into the high priority so the way it works I suppose at the minute is priority wise if you are kind of quite underweight you will be a priority*" (Dietician).

"*the joke has been like the person's so big that they nearly collapsed the bed do you know what I mean? So I do feel as in that like it is very prominent across multiple ehm levels or multiple jobs." (Personal Trainer*).
"*There's healthcare professionals including GP's that would oh there's another fat person they're in a terrible mess because of their fatness now whether they'd say that to somebody's face you know and sometimes they will say I will say to people listen we've been working this while you really you do know what the problem is here you know and I think it's...but it's pointing out the kind of obvious to them" (GP)*
"I think trainers or personal trainers is a big one, do find fat shaming is a big, big, big issue in the industry. (Personal Trainer)

Table 3: quotes that illustrate anti-fat attitudes.

Anti-fat attitudes may be due to inadequate patient-provider communication which can aid weight shame and stigma. All participants of this study were asked if they have engaged in

patient shaming. Although they appeared to be reluctant to answer, they did comment that they have witnessed weight shaming from colleagues. "*As a professional there shouldn't be any stigma around it but there is of course there is". (Nurse)*

"*…if I'm talking to them one on one so if I'm giving them an assessment or I'm going through things with them before maybe they go home I probably am very aware of it but it's the..it's the throw away comments isn't like you know we'll say if they're having their breakfast and they want the next slice of toast I might say something and I don't even realise I'm saying it". (Nurse)*
"you do see people doctors fat shaming somebody else and ah it's not nice at the end of the day humiliating people but what do you call it but then sometimes you can do it like everything it's like you can break it down to them in a nice way" (GP)
"I do think there are people that I have worked with before who would kind of have that approach that if you're obese you're lazy and you know like kind of what's the point and you know even I think like you know ehm with surgery and things like that sometimes so I think like I don't know if I even want to operate on them is it even worth it if they don't care about their health." (Nurse)
"I think trainers or personal trainers is a big one, do find fat shaming is a big, big, big issue in the industry." (Personal Trainer)
"you have to treat these people kind of like..they come to you like the weight didn't slip on overnight most of us are born less than 10 pounds you know and it's interesting when you look at the signs of it, it probably slips on its 200 extra calories a week over 2 years and that's usually how this weight slips on and then it depends too on a life event"(GP)

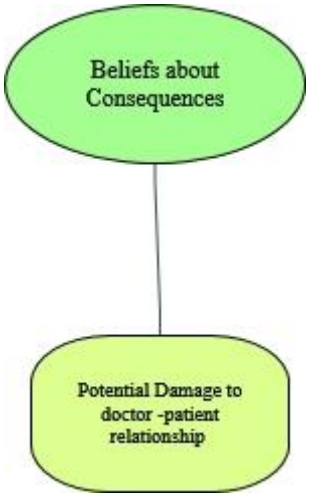
Table 4: quotes that highlight weight shaming in patients

Although health care professionals are expected to have a better understanding and knowledge to manage patients with obesity, this is not necessarily the case. This study found that often healthcare providers are often afraid of insulting their patient. "*through my training*

as a GP no as I said ask people's permission to weigh them and focus on the numbers not the..telling them it's not to do with your appearance" (GP)

In contrast, this study found that often weight stigma or shaming is not isolation to just the patient. Remarkably, the dietician reported that she has often felt shamed in her role, by not only patients and other healthcare providers. "*I just don't think they understand our profession either do you know like it's kind of people in hospital settings see a dietician and just think supplements you know like I don't know if they kind of understand our role".* She noted that patients who are not ready to change their eating behaviours often can build a perceived notion that the professional cannot empathise with them as they do not know what it is like to have weight issues "*it's kind of common as well in the profession that you know a lot of people... studies have shown and it's been talked about that you know if you're seeing someone that you know they can sometimes maybe feel uncomfortable with you if you they think that you look very slim or under -weight they might think oh well sure what does she know she's never struggled with her weight before"*

4.4 Theme 3: Belief about Consequences



Throughout the interview with the GP he expressed concern that raising the topic of weight with his patients as he felt it conflicted with the desire to maintain a non-judgemental relationship with patients. Raising the topic of weight was viewed as a threat to professional reputation. "*general practice you try and build up a relationship with somebody that you're going to take over many decades*". He acknowledges the concern about deviating from the individual's agenda and stressed the importance of treating presenting problem which appropriate expectations.

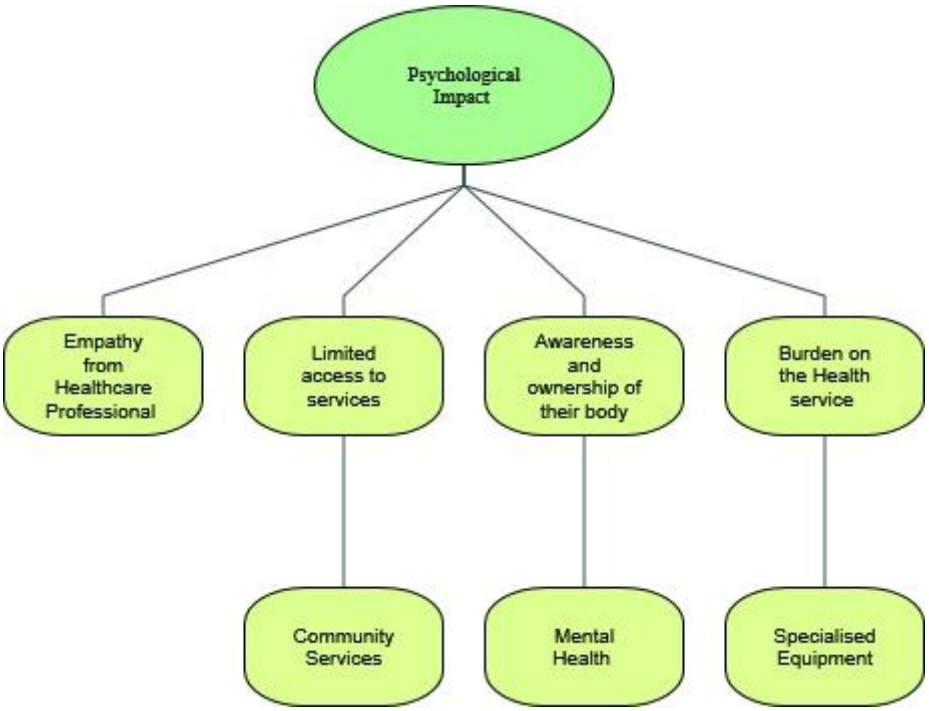
"*if you were insulting somebody about fat shaming them what do call it they won't come back to you again."*

"*it's about using the opportunity to focus on your body mass index, body mass index is useful for the vast majority of the population that are the ordinary population and saying listen the numbers here say you're a stone outside your optimum weight have you thought about losing a stone that kind of thing"*

"*You could land yourself too in hot water if you said to somebody listen the real problem is you're too fat you know and eh next thing you could find yourself at the medical council"*
"you never say that to them maybe you do that's why you're in that problem you know but the thing is if you say something like would you like to be a stone lighter if you could lose half a pound a week for 28 weeks which is just shy of 7 months you'd be 1 stone lighter and you say how would you feel if you were a stone lighter ...I'd feel great it's really easy just lose half a pound every week for the next 7 months you'd be a stone lighter.

Table 5: quotes supporting beliefs about consequences.

4.5. Theme 4: Psychological Impact



Obesity strongly characterised with negative feelings such as, disgust, anger, blame that carries detrimental psychological impacts on the individual. Throughout the interviews one emerging theme that developed was empathy. "*It can't be just a coincidence that ehm people's overall BMI and weight levels are increasing at the same rate that stress levels are increasing and obviously emotional eating is a massive thing" (GP.* Participants often drew from personal experiences to empathise with patients and the battle they face when trying to combat their weight.

"*I don't consider myself overweight but I'm uncomfortable in the gym." (Nurse)*
"there's been times when like I've been a stone heavier than I am now and eh you know I kind of realised so I know where they're coming from, I had to go off and lose a stone. I knew how hard it was and I remember the shame I felt" (GP)

Table 6: quotes that support professional empathy.

Yet, research also revealed that often psychological factors were often overlooked. "*they don't look at the psychological issues of it they don't look at maybe something that happened in a person's life that caused them like coping eating habits eh or coping habits excuse me like there's loads of reasons why a person is the size that they" (Personal Trainer).*

Obesity is strongly associated with co-morbidities such as, diabetes and hypertension. Healthcare providers often encourage their patients to lose weight yet, during the interviews the participants confirmed that there is limited to no services that accommodate for such individuals.

"*I think in terms of like the weight management services in Ireland are like really really poor ehm basically like it's something we're always kind of flagging it's just..the nutrition services are not there"* (Dietican)
"*I suppose there needs to be more resources like my experience with dieticians and nutrition is that they only kinda come see patients when they are eh post op or they don't really they kinda recommended to go see them as out-patients"* (Nurse)
"there's not alot of...I just find if you write...send a letter you know that somebody's not going to be seen for over 3 years" (GP)
"*There's not a great dietician service in our area and the problem is they're taken up mainly by children and you know paediatric cases and things like that ehm as well the dietician service wouldn't be great there'd be a long wait for it as well"* (Dietican)
*"I notice a lot of people towards weight watchers or what do you call slimming world sort of thing" (*GP*)*

Table 7: quotes that illustrate limited access to adequate healthcare services.

Individuals with weight issues commonly have mental health issues such as depression, anxiety and low self-esteem due to having a negative body image. "*it is it's massive, it brings on depression it brings on anxiety*" (Personal Trainer).

"*if you're overweight, you're predisposed to arthritis in your joints ehm diabetes high blood pressure ehm and mood problems as well all these people who are overweight just are not happy" (GP)*
"When they get sadder, they eat more and stuff like this" (GP)

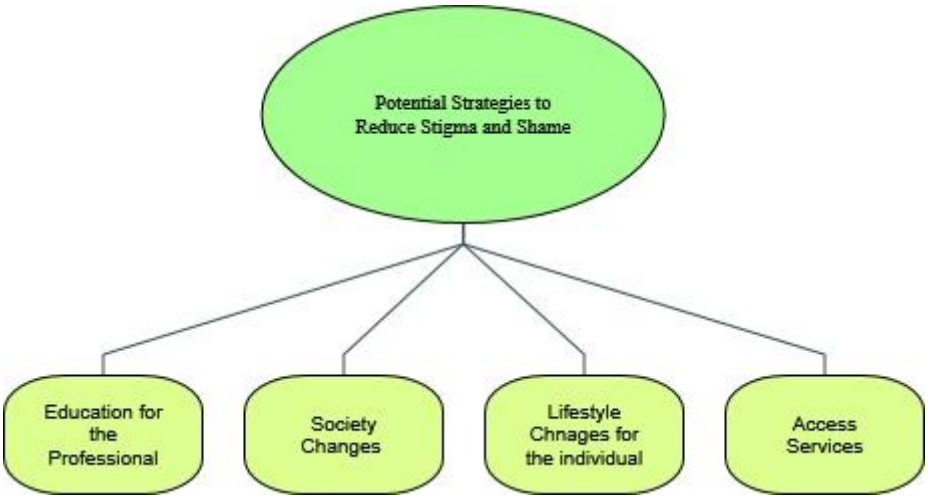
Table 8: Quotes that support mental health impact of obesity.

As previously mentioned, obesity related health issues in Ireland have estimated costs to the exchequer of €1.13 billion (HSE, 2018). "*year on year obesity is rising and this associates costs with it massive" (GP).* During the interview with the Nurse, she spoke about the financial burden obesity is having on the healthcare services and how hospitals have had to adapt by purchasing new specialised equipment.

"we've had to eh increase what we would have termed ehm obese specific equipment like beds and other instruments within the operating theatre so it's definitely eh becoming a lot more common"
"Oh well before you might only have 1 maybe in a month, you would only rent it in whereas now oh you could have anything up to 10."
"I actually did have a patient eh a number of years ago who was coming in for ehm...eh laparoscopic surgery keyhole surgery and ehm she wasn't suitable for because the instruments we would use for it were..weren't long enough ehm and she was...she was too large to do an open surgery on her"

Table 9: quotes from the interview with the nurse, who illustrated the financial impact obesity has on the healthcare service.

4.6 Theme 5: Potential Strategies to Reduce Stigma and Shame



All four participants greatly emphasised the lack of education for both the individual and at a professional level regarding obesity and weight loss methods. Nutrition education is lacking in medical training, despite the fact that dietary habits are a crucial component of self-care, disease prevention, and treatment. "*"obesity is such a complex disease like there's so many different factors like to be considered like psychological you know like different hormones their likes their dislikes there's no one size fits all." (Dietician)*

"*it's going to be education again from an early...like if you think about from what I was saying earlier on about like obese and stress ehm there's nothing..there's nothing in your nursing degree to say..we did I was only looking through my notes actually the other night and we did 2 lectures on stress in 4 years and the effect it has on the body 2 lectures, 2 hours over a 4 year course." (Nurse)*
"*We were talking alot about breaking bad news and things like that but that's more like telling somebody that they're going to die or life changing illness or something serious but as regards to something like obesity no it wouldn't have got an awful coverage when I was medical student" (GP)*

Table 10: quotes that support lack of education for healthcare providers.

To meaningfully address the obesity epidemic, it needs to be acknowledged that there is no single noteworthy intervention, it must come from enforced societal changes. This can be achieved by introducing sufficient education and policies aimed at obesity prevention.

"*I think in terms of our schools and our education like nutrition is absolutely like in primary school you do like bits of healthy eating things like that but ehm not to any great extent you get to secondary school unless you actually studies home economics or biology you don't have the first thing about food" (Dietician)*
"*there's just such a lack of awareness I think there should be...nutrition should be taught in schools 100% and once you have that kind of basic of understanding then people can make informed choices..." (Dietician)*
"I think basic education to people some don't realise you know how much how many calories are in their food ehm they think too that cooking is.. they look at tv and think cooking is something only Jamie Oliver can do with a whole myriad of ingredients and they forget that it's tough" (GP)
"I say talk to about weight management or maybe talking to them about diabetes I might ask them there's 3 main macro nutrients that we need to survive and what are the carbohydrates and I might turn around and say to someone do you know what carbohydrates are and I've never met anyone that has said yes" (Dietician)
"portion sizes too...it's really funny if you ever see a 1970's dinner serving compared to a 2020 serving the plates are massive" (GP)

Table 11: quotes that illustrate societal changes.

Obesity is largely associated with an imbalance involving both dietary intake and physical activity patterns. There are various factors such as, education that effect this disparity. However, long working hours has significantly contributed to the rising obesity problem by reducing time for physical activity, particularly for individuals working in sedentary occupations. "*the food's cheap people exercise less than before ehm you know alot of people just get into their car and drive here there and everywhere they don't walk they don't cycle as much as before" (GP)*.

"*Some people I meet get up at 6 in the morning and don't come home until 8 in the evening they have nothing left. You know at the weekend all they want to do is relax, might come home and open a bottle of wine after driving back from Dublin and you can't be...you can see why" (GP).*
"it's usually the car that gets them there sometimes public transport..people jobs are sedentary most people sit, stand at a production line or sit in an office don't do that there. (GP)
"weather doesn't help in Ireland although there's lots of fat people in Australia as well" (GP)

Table 12: quotes from interview with GP that illustrate lifestyle demands.

To conclude, an effective way of reducing shame, stigma and weight in a comprehensive manner is having suitable healthcare-based services that are easy to access. "*I think if there's more services there is someone says they're really keen to lose weight like and if there was a quick pathway for you to refer them off to like a service...like a dietician and exercise therapist like that so when the idea is fresh in their mind and they're motivated to go off they go and that would be a good thing." (GP).*

5.Discussion

5.1 Introduction

The aim of this study was to Explore Medical Professionals Experiences and Perceptions of Shaming and Stigmatisation in Patients that are Overweight/Obese. Initially, a comprehensive literature review highlighted the concerning statistics of obesity in Ireland. According to the CSO (2019) over 62% of the population is classified as overweight or obese. Puhl & Brownell (2012) suggests that obesity is a highly stigmatised condition associated with blame that is often apparent from healthcare professionals. Persistent weight stigma and shaming amongst healthcare providers can pose a significant threat to the psychological and physical health of overweight and obese people. Various factors influence stigma and shame towards individuals with weight concerns such as, lower the quality of communication between the patient and the healthcare provider. Effective communication is of critical importance when attempting to measure the impact of weight prejudice on psychological and physical health. Although weight shaming and stigmatisation amongst healthcare professionals is not a relatively new phenomenon and there is significant amount of appropriate literature available, there is no research addressing Irish healthcare professionals' experiences and perceptions of stigmatisation and shaming of overweight/obese individuals.

5.2 Research Questions

This current research aimed to bridge that gap in the literature by answering the following research questions.

RQ1: What are the healthcare professional's experiences of working with individuals who are overweight or obese.

RQ2: What are their perceptions towards stigmatisation and shame towards patients with weight issues?

RQ3: Have they been guilty of blaming their patients weight issues?

5.3 Healthcare Professional's Experiences of working with individuals who are overweight or obese

Several studies explored healthcare professionals' attitudes and beliefs about working with individuals who are overweight as well as obesity (Tham & Young, 2008 & Poon & Tarrent ,2009). Results of these studies showed a significant number of individuals with weight issues found that healthcare professionals can often be ambivalent towards them. Considered the gatekeepers of the medical health services, GP's can often fail to engage with patients regarding their weight concerns. Furthermore, preventing them from accessing specialised referral services. During the interview with the General Practitioner, he acknowledged that he is often reluctant to acknowledge a patient's weight "*I ask people's permission to weigh them and focus on the numbers not the..telling them it's not to do with your appearance*". During this interview he addressed that the epidemic of obesity is rising *"people are getting fatter there's no doubt about it and the number of people coming through the door that are overweight or obese compared to when I would have been... say 15 years ago it increases...it increases every as every few years.*

Additional, explanations as to why healthcare professionals are hesitant to address weight concerns is due to the limited understanding and training about obesity care. This is supported by Sanchez-Ramirez et al., (2018) who revealed that mainly due to not having enough resources such as, current assessment and counselling strategies, and behaviour management to deal with this issue medical professionals recline from tackling weight

concerns. All participants agreed that there was inadequate access to referral services "*if you write...send a letter you know that somebody's not going to be seen for over 3 years".*

Furthermore, all four participants of the study revealed that there is a generalised misunderstanding in relation to obesity. Often, it is alleged that obese people have gained the weight due to lack of physical activity and eating poorly nutritious foods. Throughout the interview with the Dietician it was noted that obesity is a complex disease that is caused many different factors. Throughout the interviews it was acknowledged that lifestyle factors contribute massively to an individual being overweight or obese. Research by Wadden et al., (2012) stated that long working hours has significantly contributed to the rising obesity problem by reducing time for physical activity, particularly for individuals who are commuting long hours and working in sedentary occupations. The GP stated that "*Some people I meet get up at 6 in the morning and don't come home until 8 in the evening they have nothing left.".* this can greatly impact on the mental health of the individual who then seek comfort from negative outlets such as, alcohol "*know at the weekend all they want to do is relax, might come home and open a bottle of wine".*

Lastly, an isolated issue that arose during the interview with the GP about his experience of working with individuals who are overweight or obese was the potential to damage the doctor–patient relationship. "*general practice you try and build up a relationship with somebody that you're going to take over many decades".* During this interview he acknowledged the role of professionalism. It was noted that if patients potentially feel victimised and perceive shame and stigma regarding their weight, this could be counterproductive and alienate patients from consulting in the future. *"if you were insulting somebody about fat shaming them what do call it they won't come back to you again"*

5.4 Perception towards stigmatisation and shame towards patients with weight issues.

Puhl & Brownell (2012) suggests that obesity is a highly stigmatised condition associated with blame that is often apparent from healthcare professionals. Persistent weight stigma and shaming amongst healthcare providers can pose a significant threat to the psychological and physical health of overweight and obese people. Various factors influence stigma and shame towards individuals with weight concerns such as, lower the quality of communication between the patient and the healthcare provider. Effective communication is of critical importance when attempting to measure the impact of weight prejudice on psychological and physical health.

Healthcare providers are to some extent aware of the level of stigmatisation and shame placed upon patients with weight issues. Research reviewed by Puhl & Heuer (2009) demonstrated that healthcare providers endorse stereotypical assumptions about individuals with obesity and characterise obesity to blame. During this study the participants were asked about their opinion on shame and stigmatisation of overweight patients. The GP stated that "*doctors fat shaming somebody else and ah it's not nice at the end of the day humiliating people"* establishes that shaming exists at the grass roots level of the health service. Health care settings can generate a normative culture-producing stigma that can be often adopted by individuals with obesity leading to negative responses. Puhl & Heuer (2009) additionally reports that when healthcare providers displayed an ambivalent attitude towards obesity it can often create an increase in maladaptive behaviours such as, overeating, exercise avoidance and a reluctance to lose weight. Unpardonably, however, the literature revealed that doctors reported significantly fewer negative attitudes than what their patients perceived.

Paradoxically, the interview with the Dietician revealed that often shame and stigma is not exclusively directed towards the patient. She revealed that often patients who are

overweight can often develop a preconceived belief that Dieticians have never struggled with their weight "*what does she know she's never struggled with her weight before"* and therefore, develops a barrier and resistance to change. This reaction from the patient and disregard for the healthcare providers advice can contribute greatly to the inactivity and potential engagement in patient shaming.

5.5 Healthcare Professionals guilty of engaging in patient blame.

Through in-depth interviews with healthcare professionals from a degree of different backgrounds surprisingly revealed similar results when asked if they have been guilty of engaging in patient blame. All four participants denied activity engaging in it but stated that they have witnessed it or if they did engage in it, it was done without malice. Blame tended to be placed on others or the systems failing rather than reflecting on their own interactions. These set of interviews all spoke about the lack of services available and how that greatly contributes to the level of obesity. "*in terms of like the weight management services in Ireland are like really really poor ehm basically like it's something we're always kind of flagging it's just..the nutrition services are not there".*

As previously discussed, the interview with the GP revealed that if weight was mentioned during a consultation with a patient, he was often cautious about mentioning someone's weight and asked for permission to weight them. There is a certain level of uncertainty about how to initiate weight loss discussion between the doctor and patient especially when the individual is presenting with problems unrelated to excess weight. These actions, although highlighting signs of respect and dignity to the individual, largely underwrite the failings of the system. What healthcare professionals are guilty of is not tackling obesity at a primary healthcare access point which then implicates that the system does not work.

In a study by Puhl & Heuer (2009) it was suggested that people who are overweight or obese are often described as being lazy, unmotivated, sloppy and lacking self-discipline. This, therefore, leads to the development of a negative stereotype of these individuals and the thought that they are unwilling to change. All participants were asked how they feel when patients who have weight issues do not adhere to medical advice? The question extracted a degree of mixed responses mainly from the PT to the GP. The PT stated when a person does not take his advice it can be frustrating as they have put time into developing a programme to aid them to lose weight and in turn lead a healthier life. On the other hand, the GP states "*people don't take your advice all the time still smoking still drinking..you wouldn't fall out on that it's different...I think if you were a hospital specialist you could and somebody's come in and their diabetic you could say listen I'm sick of you, you're not making any effort something like that but you won't fall out and say listen just keep working there's no point in going to war with them they've enough problems in their life without ehm an argument with their doctor.* Again, the apathy and lack of enthusiasm to challenge the individual to lead a better and healthier life demonstrates greatly the healthcare professionals lack of education and training in the area of obesity.

5.6 Strengths and Limitations to the current study.

This study explored Irish healthcare professionals such as, general practitioners and nurse views and experiences on weight shaming and stigmatisation. To date there is no published research exclusively addressing this in Ireland.

The inclusion of healthcare providers from a degree of different sectors provides novel insight into the research problem.

Additionally, it explores the barriers to raising the topic of weight in general practice, and found that healthcare providers encounter significant barriers such as, a lack of services.

As with the majority of studies, the design of the current study is subject to limitations. The initial limitation of this study included the small sample size. This study had a sample of four participants from a range of healthcare sectors. Due to time restraints of this study, the researcher was unable to conduct a significant number of qualitative interviews to gain a comprehensive overview of the experiences and perceptions of healthcare professionals across Ireland.

The four interviews that were conducted provided a wide range of information, yet, some participants contributed more beneficial evidence. A fifth participate was asked to partake but failed to regain contact with the researcher.

If this study was conducted again, using healthcare professionals from the same sector such as GP's would provide more in-depth data as a comparison could be conducted.

A further regret of the researcher includes not using a mixed methods approach. Post analysis found that often the participants did not delve deep about the professional shame. A survey may have provided a specific question that, in retrospect, could have addressed professional shame that allowed anonymity unlike a qualitative interview.

5.7 Future Studies

Research on healthcare professionals' experiences on shame and stigmatisation on weight issues does not exist in Ireland. Further studies primarily addressing GPs opinions on obesity is essential as they are the initial point of contact to leading a healthier life.

5.8 Conclusion

Healthcare professionals endeavour daily to provide the highest quality health care for all. Yet, research suggests that then less than half of individuals that are overweight or obese are advised by healthcare professionals to lose weight. This inactivity from the healthcare

professional is caused by multiple factors such as, uncertainty about how to raise the topic of weight, fear of alienation, fear of damaging doctor-patient relationships, lack of education about obesity from the healthcare provider and competing demands and limited time due to life. The level of inertia expressed by healthcare professionals is furthermore, hindered by the interactions of interpersonal and environmental cues that that portray individuals with weight issues are a burden on the healthcare system. This creates weight stigma and shame. In conclusion, stigmatisation and shaming towards individuals who are overweight or obese exists to a great extent amongst healthcare professionals, even in an Irish context.

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Appendices

Appendix A:

Consent Form:

To whom it may concern,

My name is Susan Gallagher, I am a student of Dublin Business School studying a HDip in Psychology. For my degree year I must complete a research study; my research study is titled "Exploring Medical Professionals Experiences and Perceptions of Shaming and Stigmatisation in Patients that are overweight/obese"

The participants which I am researching are Medical Professionals working on the frontline in Healthcare.

The names of the participants **will not be disclosed** in any data that will be published; in the event of publication, the research participants will be contacted. The participants have right to refuse to partake; however, once the interviews have been conducted the obtained information will be used.

The interviews will take approximately 30 minutes. The transcripts of each interview will be kept in a safe manner in a locked cabinet that only the researcher has access too. At the end of the research the transcripts and recordings will be disposed of appropriately.

I, _____ agree to participate in the interview.

Interview ☐ (**Please Tick**)

If any issues arise for you during this research, please do not hesitate on contacting the following organisations:

If there are any further questions please do not hesitate to contact the researcher:

Susan Gallagher: [redacted]@mydbs.ie

Appendix B:

Semi Structured interview Schedule

Initial questions:

1. Can you tell me a brief background to your profession?

- Can you tell me about your experience of working with patients who are overweight/obese?
    - Have you noticed an increase in the number of patients you see who are overweight/obese?
- Have you noticed an increase in metabolic conditions (such as diabetes, high cholesterol etc) in patients that are overweight/obese? If so, can you elaborate.
- What sort of advice have you provided to your patients? And what has happened?
- How do you feel if they don't take your advice? Do you get frustrated when they potentially don't take your advice?
- How do you feel after you have spoken to a patient who has expressed concern over their weight?
- Are you aware of how you communicate to you patients regarding sensitive topics such as weight?
- Can you remember if a patient has ever expressed shame or stigmatisation regarding their weight? If so, what did they say?
- What is your opinion of patient shaming or stigmatisation?
- Do you believe shaming exists within the context of healthcare? If so, could you explain further?
    - Without giving names or specific details could you outline examples of when you think shaming has occurred?
    - Does the media play a role in shaming? They have created an image of the ideal figure/beauty? What is your view or opinion on this?
        - ***Specific interviewee questions***
        - Within your social media platform, you mentioned shaming and patient blame, what responses did you receive from your followers and colleagues?
        - What concerns if any did you have when you mentioned blaming/shaming from a professional standpoint?

- What are your perceptions of patient shaming? Do you think you have ever been guilty of engaging in it?
    - What is your definition of patient blaming?
    - Do you believe that people resist change?
    - What do you think can be done to help reduce professional blame?

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Appendix C:

Information sheet

Exploring Medical Professionals Experiences and Perceptions of Shaming and Stigmatisation in Patients that are overweight/obese.

Who is the researcher and what is this study is about?

My name is Susan Gallagher and I am currently studying the Higher Diploma in Psychology in DBS. I studied Health Promotion as my undergraduate degree and have an extensive interest in health psychology. Research has revealed that Ireland is on course to become the leading country in the EU for rates of overweight/obese; this study will address shaming and stigmatisation of individuals who are overweight/obese by interviewing medical professionals who are working on the frontline.

What will taking part involve?

By agreeing to partake in this study, an interview will be conducted. The interview will last about 40minutes and will be conducted at a venue of choice between the researcher and participant. The interviews will be recorded using a Dictaphone and will be transcribed post interview; these transcripts will be then analysed for data.

Why have you been invited to take part?

The participants of this study are medical professionals that work directly with patients; medical professionals will have rich information that will be influential to this study.

Do you have to partake?

Participation of this study is voluntary and you have the right to refuse to participate. A consent form will be administered prior to the interviews; however, once the interviews have been conducted the right to refuse to participate will be revoked. No names will be used throughout the research or any published data.

What are the benefits and risks to partaking?

The are shaming in clinical encounter is underacknowledged and under studied. Therefore, by participating you are providing rich information that will help address the gap in the research. At present, there are no harmful risks in participating.

Will taking part be confidential?

No names will be mentioned in any published research; each participate will be given acronyms. Direct quotes will be used to support the research but these will not be identifiable through the use of the allocated acronyms. Consent forms will be stored in a locked cabinet and the researcher will be solely responsible for any received data; however, the data will be shared with the supervisor of the study if required. A Dictaphone will be used to record the interviews and the participants may be identifiable via their voices; however, the recording will be stored securely.

How will the information you provide be recorded, stored and protected?

The research will be stored for five years following the completion of this study. The audio files and transcripts will be stored on the researcher's private laptop that has encrypted access codes. Data that needs be retained for storage over the five years include the consent forms, all raw data (interview transcripts) and any data that was coded during the analysis. Due to GDPR restrictions, for long-term storage all data needs to be saved electronically, including consent forms; therefore, these will be scanned and saved. At this point the researcher will encrypt all data in order that it can be transferred securely. Furthermore, the laptop has update anti-virus software.

What will happen to the research?

On completion of the research for assessment towards academic award, the research may go towards publication on the DBS website. If the research published further, then any participant will be contacted.

Who should you contact for further information?

If you have any further questions, please do not hesitate to contact the researcher or supervising researcher.

Susan Gallagher: [redacted]@mydbs.ie

Supervisor:

Thank you.