Received: 22 March 2024 | Revised: 27 August 2024 | Accepted: 4 September 2024

DOI: 10.1002/osp4.70008

ORIGINAL ARTICLE

Obesity Science and Practice Open Access WILEY

Clinical observations of weight stigma among nursing students: A descriptive approach

Myah Kerbyson[1] | Kristen D. Clark[1,2]

[1]Department of Nursing, University of New Hampshire, Durham, New Hampshire, USA

[2]Department of Medical Sciences, Uppsala University, Uppsala, Sweden

Correspondence

Kristen D. Clark, Akademiska sjukhuset, ingång 10, plan 3, Uppsala 751 85, Sweden.
Email: kristen.clark@uu.se

Abstract

Background: Mistreatment of individuals due to their body size or weight stigma has been described as a source of stress and as a deterrent for engagement in the healthcare system. Efforts to reduce weight stigma have included curricular interventions to reduce weight bias among future healthcare professionals. However, few studies have examined students' observations of weight stigma and subsequent socialization to healthcare environmental norms.

Aims: The purpose of this study is to evaluate observed weight stigma among prelicensure nursing students and recent graduates during clinical rotations and its effect on the perceived ability to provide respectful care to people in larger bodies.

Materials and Methods: A cross-sectional, descriptive study was conducted from February to March 2023. Participants answered questions related to personal weight bias (Fat Phobia Scale), observations of weight stigma, and perceived ability to provide respectful care.

Results: Ninety-one participants completed the survey, of whom half ($n = 48$) held a high level of weight bias. A quarter of participants ($n = 23$) reported that they engaged in weight stigma behaviors and a quarter ($n = 24$) of participants observed weight stigma behaviors from two or more healthcare professional roles. Almost one-third ($n = 10$) of participants who observed weight stigma behaviors perceived that it impacted their ability to provide respectful care to patients in larger bodies.

Conclusions: These findings describe that weight stigma enacted by multiple healthcare professional roles is observed by nursing students during clinical rotations and is perceived to impact their ability to provide respectful care. Efforts to improve healthcare professionals' sensitivity to the effects of weight bias and weight stigma should include addressing the role of socialized norms on weight bias among future healthcare professionals.

KEYWORDS

clinical, faculty, obesity, stigma, weight bias

1 | INTRODUCTION

Weight bias refers to the social structures, beliefs, and attitudes that assume and prioritize thinness; ascribing fatness, or living in a larger body, as a personal or moral failing.[1,2] Weight bias leads to weight stigma; for example, a nurse with weight bias may believe that people in larger bodies are lazy and do not try hard enough to lose weight. This may lead to weight stigma if the nurse ignores a patient's request for walking assistance because they perceive the patient as fat and assume that they will refuse due to perceived laziness. Weight bias and weight stigma in the healthcare system have a detrimental impact on patients in larger bodies and have been observed among numerous healthcare professional roles, including physicians, nurses, dietitians, and physical therapists.[3,4] Denial of healthcare services and the refusal to provide referrals have also been described by people living in larger bodies, as well as experiences where these patients perceived an overall lower quality of care.[5,6] People in larger bodies describe outdated, oversimplified advice when receiving healthcare, such as "eat less, move more," which they describe as impersonal and unsupportive, and insinuates that the cause of their larger body size is a lack of self-control or desire to make such changes.[5,7] A lack of supplies and resources is also observed by patients in larger bodies, such as difficulty finding a correctly sized blood pressure cuff and hospital gown.[7] These explicit and implicit forms of weight stigma result in delays in care delivery and contribute to the internalization of weight stigma, such as when a person in a large body feels negatively about themselves due to their weight or body size or the anticipation of weight stigma.[7]

Internalized weight stigma impacts an individual's sense of self-worth and their decision-making related to healthcare. People in larger bodies express feeling deterred by the anticipation of weight stigma, such as the expectation that their symptoms will be attributed to weight and not investigated fully.[7] Studies examining internalized weight stigma among women, for example, found an association with avoidance of follow-up and continuation of treatment in specialty settings, such as psychiatric[8] and obstetric care.[9] The effects of explicit, implicit, and internalized weight stigma are also associated with poor health outcomes, such as heart disease, arteriosclerosis, stroke, diabetes, depression, and anxiety.[10,11] Although obesity is often attributed as a primary cause of many poor health outcomes, the experiences of weight stigma play a role and inhibit patient efforts to change their weight.[4] Addressing weight bias and subsequent weight stigma are important areas of opportunity to address deficits in healthcare delivery through improved experiences with healthcare professionals.

Nurses make up the largest healthcare workforce, with 27 million nurses and midwives globally[12] and nearly 5.2 million registered nurses (RNs) in the United States (US).[13] Nurses are also the healthcare professionals who spend the most time engaging in direct patient care.[14] Therefore, reducing weight bias and weight stigma among nurses is a key opportunity to improve healthcare delivery to people with larger bodies. Interventions to reduce weight bias have been examined among nursing students, such as case-based learning,[15] weight sensitivity training,[16] and simulation scenarios.[17,18] However, it is within clinical settings, where nursing students work with a multidisciplinary healthcare team, that weight bias and weight stigma are normalized and reinforced. These observations and role modeling by healthcare professionals may counteract efforts made in controlled environments such as the classrooms and simulations. Therefore, the aim of the present study is to evaluate the types and sources of weight stigma observed by pre-licensure nursing students and recent graduates during their clinical rotations. Secondarily, the aim is to assess students' perceived ability to provide respectful care to people in larger bodies and whether it is affected by observations of weight stigma.

2 | MATERIALS AND METHODS

2.1 | Recruitment and procedures

An exploratory, cross-sectional, descriptive study was conducted to address the identified aims. A Qualtrics questionnaire was distributed via email to a nursing student distribution list at a university in the northeastern US and on social media groups for US nursing students (i.e., Facebook, Instagram) between February and March of 2023. The survey took approximately 30 min to complete. The survey included two sections on clinical observations, one on observations related to caring for lesbian, gay, bisexual, transgender, and queer (LGBTQ+) patients and a second module on observations related to weight stigma. The present study reflects the subsection of data related to weight stigma. Inclusion criteria required that participants be 18 years or older, able to read and respond to questions in English and be either (1) currently enrolled in a pre-licensure nursing program (associate's, bachelor's, or master's entry to nursing practice) in the US and also have completed one semester of clinical experience or (2) a recent nursing graduate who has been practicing as an RN in the US for less than 2 years. The present study was evaluated and approved by the Institutional Review Board at the University of New Hampshire (IRB-FY2023-104). Informed consent was provided after completion of the screening questions at the beginning of the survey. Participants could indicate on the survey whether they consented to participate. Participants were offered to enter a raffle for a $50 gift card upon survey completion.

2.2 | Measures

2.2.1 | Demographics

Demographic questions included age, gender identity, sexual orientation, race, ethnicity, student status, type of nursing program, and self-perceived body weight. Age was measured using an ordinal variable. Gender identity, sexual orientation, and race were measured using select-all-that-apply variables with an open-text response option if the desired selection was not present. Ethnicity

was measured by asking participants to indicate whether they were Hispanic or Latino/a/x/e by checking yes or no. Participants were asked to indicate their student status with two items: one to indicate if they were a current nursing student or a new graduate and a second to indicate the type of nursing program they were enrolled in or recently graduated from (i.e., 2-year program, 4-year program, RN-BSN, graduate entry to practice program, or other with an open-text box). Participants were asked to indicate how they perceived their body type by choosing one of the following options: underweight, average weight, overweight, or significantly overweight.

2.2.2 | Weight bias

The 14-item Fat Phobia Scale-short form was utilized to measure participants' attitudes and beliefs toward people in larger bodies or their personal weight bias.[19] This scale was chosen because of its use among healthcare professionals and its measurement of explicit forms of weight bias.[3,20] The scale was tested in two samples and found to demonstrate strong reliability (α = 0.87–0.91) and a high correlation with the original 50-item scale (r = 0.82 and 0.90).[19] The participants were asked to score their associations between the provided adjectives and people in larger bodies on a scale of 1–5, where 1 was a positive attribute/stereotype and 5 was a negative attribute/stereotype (e.g., 1 = fast and 5 = slow). Half of the items were reverse-coded. These seven items were recoded to be directionally consistent with the rest of the scale. All items were summed and divided by 14 to create a single variable with a range from 1 to 5. A score <2.5 was interpreted as having neutral or positive attitudes, a score from 2.5 to 4.4 was interpreted as low weight bias, and a score >4.4 was interpreted as high weight bias.

2.2.3 | Observations of weight stigma

A list of 10 weight stigma behaviors was identified from a literature review on experiences of weight stigma (described as weight bias) that impacted healthcare access.[7] Participants were prompted, "Which of the following have **you** done in a **clinical setting** when caring for a patient of a larger size (sometimes described using the terms obese or fat)?" and could select all of the items that applied. Participants were then asked, "Which of the following have you observed **your clinical instructor** doing in a **clinical setting** when caring for a patient of a larger size (sometimes described using the terms obese or fat), check all that apply" and provided the same 10 items. This question was prompted twice more, but the healthcare professional role was changed to "nurse or nursing assistant" and then "provider or another healthcare professional."

Two qualitative items were provided to further contextualize weight stigma within the sample and clinical observations. Participants were first asked, "Please describe why or provide a story about an experience that represents your discomfort caring for patients of a larger size (sometimes described using the terms obese or fat)." The second item asked, "Please describe one or more scenarios that relate to an experience that was checked off above." Participants were reminded to use caution to refrain from reporting any specific details that could disclose patient identities or otherwise violate the Health Information Patient Protection Act (e.g., names of hospitals or patients). An open-text box was provided for responses.

2.2.4 | Ability to provide respectful care

Participants who described at least one observation of weight stigma were provided two items that asked about whether those observations affected the clinical care they provided and their personal feelings toward patients in larger bodies. The impact of observed weight stigma on students' perceived ability to provide respectful care was measured using the prompt, "Do you agree with the following statement: the events checked off above have made it much more difficult for me to provide affirming care to patients of a larger size (sometimes described using the terms obese or fat)." The perceived relationship between observed weight stigma and students' feelings toward patients with larger bodies was measured using the prompt, "Do you agree with the following statement: my clinical experiences have affected my feelings about caring for patients of a larger size (sometimes described using the terms obese or fat)." Participants responded to each prompt using 5-point Likert-type scales with response options ranging from "strongly disagree" (1) to "strongly agree" (5).

One qualitative item to further contextualize responses about students' feelings about caring for patients in larger bodies was provided. Participants were asked, "Please elaborate on how clinical observations have impacted your feelings about caring for patients of a larger size (sometimes described using the terms obese or fat)." An open-text box was provided for responses.

The ability to provide respectful care to patients in larger bodies is also impacted by whether there is access to necessary resources and equipment as well as knowledge and training of their proper use. Participants were asked about their access to, and confidence using, assistive devices for moving or lifting patients using two items. The first item asked students, "Which of the following do you have access to at your facility" and asked participants to select all of the following options that apply: Hoyer lift, stand assist lift, gait belt, and slide sheet. The second item asked, "Which of the following do you feel confident using" and asked participants to select all devices that they felt confident using, with the same answer choices.

2.3 | Analysis

Quantitative analyses were conducted with Stata software version 15.1.[21] Descriptive statistics were used to evaluate and describe quantitative items related to participant demographics, weight bias, observations of weight stigma, and ability to provide respectful care. Qualitative open-text responses were exported to Excel and any

TABLE 1 Demographic characteristics of pre-licensure nursing students and recent graduates ($N = 91$).

Demographic characteristic	*N* (%)
Age	
18–25 years	80 (93.2)
26+ years	6 (6.8)
US region	
Northeast	91 (100.0)
Gender identity[a]	
Man	6 (6.6)
Nonbinary/genderqueer	1 (0.01)
Woman	79 (86.8)
Not reported	5 (5.5)
Sexual orientation[a]	
Bisexual	7 (7.7)
Gay/lesbian	1 (0.01)
Heterosexual/straight	78 (85.7)
Queer	1 (0.01)
Not reported	5 (5.5)
Race and ethnicity[a]	
Asian/Hawaiian/Pacific Islander	6 (6.6)
Hispanic or Latina/e/x	3 (3.5)
Multiracial	2 (2.2)
White	82 (90.1)
Not reported	3 (3.3)
Student status	
Current student	77 (88.5)
Recent graduate	10 (11.5)
Type of nursing program	
2-year associates	3 (3.3)
4-year bachelors	78 (85.7)
Other	4 (4.4)
Current year in nursing program	
2nd	40 (44.0)
3rd	17 (18.7)
4th	19 (20.9)
Weight bias	
Neutral/positive attitudes	5 (5.5)
Low weight bias	38 (41.8)
High weight bias	48 (52.8)
Perceived body size/weight	
Underweight	3 (3.3)
Average weight	63 (69.2)
Overweight	15 (16.5)
Significantly overweight	2 (2.2)
Not reported	8 (8.8)

[a]Participants could select all options that apply.

instance of potentially identifiable patient or participant information was removed. Thematic analysis, with an inductive approach and line-by-line coding, was used for analysis.[22] Two independent coders reviewed the responses and identified themes. Representative quotes were selected to illustrate the themes for each prompt.

3 | RESULTS

Table 1 reflects the full sample demographic details. A total of 91 participants were included in this study. The majority of respondents were cisgender women ($n = 79$, 86.8%), white ($n = 82$, 90.1%), non-Hispanic ($n = 88$, 96.5%), and under 25 years old (93.3%, $n = 80$). The full sample ($N = 91$) attended nursing programs in the northeast US (i.e., Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont), Almost 90% were students ($n = 77$), and the majority of participants were either currently enrolled in, or recently graduated from, a 4-year pre-licensure nursing program ($n = 78$, 85.7%). Of the students currently enrolled, the majority were in the second year of their nursing program ($n = 40$, 44%). Almost 70% of participants described themselves as having average weight ($n = 63$). Just over half ($n = 48$) of participants had high weight bias scores ($\alpha = 0.85$ in the present study) and only 5.5% ($n = 5$) had neutral or low weight bias scores.

3.1 | Observations of weight stigma

3.1.1 | Observations of weight stigma: Quantitative findings

Table 2 presents the full descriptive results detailing individual weight stigma behaviors and specifying participants' reports of the healthcare team role observed engaging in them. When asked to indicate which weight stigma behaviors they *personally* have engaged in while in their clinical settings, 25% ($n = 23$) of participants endorsed at least one weight stigma behavior, and almost 9% ($n = 8$) indicated two or more. The most common weight stigma behavior reported was "blaming a patient's medical or psychological condition on their body size" ($n = 10$, 10.9%). When asked about weight stigma behaviors they observed when working with *their clinical instructor*, almost 19% ($n = 17$) reported at least one, with 14% ($n = 13$) describing two or more behaviors. Participants equally observed two items most frequently when working with *their clinical instructors*,

TABLE 2 Frequency of weight stigma behaviors in clinical settings by the individuals who engaged in them as reported by participants.

	Individual who engaged in weight stigma behaviors			
Weight stigma behavior	**Participant**	**Clinical instructor**	**Nurse or nursing assistant**	**Provider/other professional**
Shared weight with others to whom it was not directly relevant	7 (7.6)	8 (9.8)	16 (17.4)	6 (6.5)
Used derogatory terms or slurs to describe a patient	2 (2.2)	3 (3.3)	13 (14.1)	5 (5.4)
Made judgmental comments about a patient's habits	8 (8.7)	9 (9.8)	21 (22.8)	13 (14.1)
Blamed a patient's medical or psychological condition on their body size	10 (10.9)	8 (8.7)	17 (18.5)	13 (14.1)
Assigned personal blame to a patient for their body size	5 (5.4)	6 (6.5)	18 (19.6)	13 (14.1)
Laughed about a patient's weight or ability	0 (0.0)	2 (2.2)	9 (9.8)	3 (3.3)
Made comments about a patient's appearance to/in front of the patient	8 (8.7)	5 (5.4)	8 (8.7)	4 (4.4)
Made excessive comments about difficulty transferring or moving a patient	0 (0.0)	9 (9.8)	15 (16.3)	7 (7.6)
Blamed a patient for difficulty moving or transferring	4 (4.4)	6 (6.5)	14 (15.2)	5 (5.4)
Suggested weight loss as a solution for an unrelated medical problem	0 (0.0)	7 (7.6)	11 (12.0)	14 (15.2)

"making judgmental comments about a patient's habits" and "making excessive comments about difficulty transferring or moving a patient" (n = 9, 9.8%). When asked about weight stigma behaviors they observed when working with *nurses or nursing assistants* in their clinical settings, one-third (n = 28) reported at least one, with a quarter (n = 23) reporting two or more behaviors. Participants reported that "making judgmental comments on a patient's habits" was the most common weight stigma behavior observed when working with *nurses or nursing assistants*. When asked about weight stigma behaviors they observed when working with *providers or other healthcare professionals* in their clinical settings, a quarter of participants (n = 23) reported at least one, with almost 21% (n = 19) reporting two or more behaviors. Participants reported that "suggesting weight loss as a solution for an unrelated medical problem" was the most common weight stigma behavior observed when working with *providers or other healthcare professionals*.

This study also examined whether students or recent graduates were exposed to weight stigma behaviors from multiple healthcare professional roles (i.e., their clinical instructor, nurses or nursing assistants, and providers or other healthcare professionals). Approximately a quarter (n = 24) of participants observed these behaviors from two or more roles. Almost 17% of participants observed weight stigma behaviors from all healthcare professional roles.

3.1.2 | Observations of weight stigma: Qualitative findings

Responses to the prompt, "Please describe why or provide a story about an experience that represents your discomfort caring for patients of a larger size," were analyzed. Four themes were identified: *blaming*, *discomfort*, *fear of injury*, and *resource challenges*.

Blaming. This theme is related to the participant attributing outcomes or patient needs as primarily due to their weight or body size and was assumed to be within their control or a result of some personal flaw. This participant's response grouped the patient's difficulty assisting in their care and their frequent admissions with their body weight, insinuating that the weight was the cause instead of the condition the patient was admitted to treat.

> I had a patient who was over 500 lbs and a 'frequent flyer' and having trouble moving, transferring, cleaning and she had a manipulative personality.

Discomfort. This theme describes participants' feelings of awkwardness or embarrassment or perception of the patient's feelings. Some participants felt discomfort about how their own body image came up in the course of providing care to patients with larger bodies. In this example, both the participant's body image was a factor as well as the patients' negative comments on their own bodies:

> I get uncomfortable when the patient makes derogatory comments about themselves, or make a reference to my own size. When they make comments about themselves depending on the situation I try my best to respond therapeutically, but when comments are made about being my size I generally tend to ignore them and continue on with whatever conversation as it really takes me aback.

Fear of injury. This theme describes the fear or anticipation of harm that may arise during the provision of care related to a patient's body size. This theme arose in relation to both the participant's fear of injuring themselves and their fear of the patient being injured.

> My concern with caring for overweight patients is more so due to concern for my body mechanics because I have experienced many cases in which an overweight patient needs assistance with getting out of bed for example, and there aren't proper protocols in place to help them get up in a way that makes me feel comfortable, which puts me and the patient at risk of injury.

Resource challenges. This theme describes the anticipation of inadequate resources, such as materials, knowledge, time, or assistance, to meet the needs that may arise while caring for a patient in a larger body. This theme overlapped considerably with two other themes, *discomfort* and *fear of injury*. Participants described difficulty providing care because of a lack, or limited availability, of resources that led to feelings of discomfort due to the fear of injury.

> I think some of the discomfort has to do with fear of getting injured. the safety equipment is not always available and the patient will say 'go slow' or something like that; if the person is not in a bariatric bed there is not enough room to help them turn. People don't know how to move or work the bariatric beds or they are not fully charged and it is hard to push a 500-pound person in a bed.

Responses to the prompt, "Please describe one or more scenarios that relate to an experience that was checked off above" related to their observations of weight stigma behaviors were also analyzed. Four themes were identified: *assumptions of laziness*, *mocking or dehumanizing patients*, *patient viewed as a burden*, and *weight/size assumed to be primary problem*.

Assumptions of laziness. Participants described instances where they observed patients' needs in their clinical settings as being attributed to laziness instead of the condition that caused their admission: These attributions were made specifically due to the patients' body size or weight.

> I had a patient that was obese and it was difficult to move them at all, but at home they were independent. So I think it was difficult for people not to just assume that she was lazy in the hospital when she was unable to roll or transfer.

Mocking or dehumanizing patients. This theme describes observations of patients in larger bodies being demeaned, degraded, treated as a joke, or otherwise conveyed that their lives do not matter. A participant described a situation where a patient who was not conscious was degraded.

> We had a larger patient who was A&O x0, and incontinent x2. We needed to clean and change the pt [patient], and one of the nurses complained openly and in front of the pt [patient] that the pt [patient] was difficult to move/ turn, ripped open their briefs and provided no privacy.

Patient viewed as a burden. This theme describes how patients with larger bodies are perceived as an extra set of tasks or additional required labor placed on the healthcare professional. One participant described how this perception of the patient as a burden began before meeting them based on their body mass index (BMI) alone.

> People see the BMI and sometimes dread taking care of them because they are afraid of getting hurt. I try to be fair to people and take them as individuals. How other people behave or what they say, I try not to have that impact my care. Shaming them for their body is not going to make them wake up a normal weight.

Weight/size assumed to be the primary problem. This theme describes occurrences where a patient's symptoms or illness are assumed to be a result of their weight or size. In one instance, the participant described how she observed,

> [the] behavioral health nurse suggested a patient should 'just lose weight' if she no longer wanted to be depressed.

3.2 | Ability to provide respectful care

3.2.1 | Observations of weight stigma: Quantitative findings

Participants who observed at least one weight stigma behavior were asked whether those observations impacted their ability to provide respectful care to patients in larger bodies. Approximately 28% of participants ($n = 10$) agreed that it did impact their ability to provide such care. These participants were also asked whether the observed weight stigma behaviors affected their feelings toward patients in larger bodies. A third of the participants ($n = 12$) agreed that it did affect their feelings toward patients.

The availability of assistive devices to lift or move patients was also evaluated (Table 3). Stand assist lifts were least often reported to be available to participants, as 66% ($n = 60$) indicated they were unavailable. Slide sheets and Hoyer lifts were almost equally accessible to participants ($n = 40$, 44% and $n = 41$, 45.1%, respectively). Gait belts were the most often reported to be available, with almost half ($n = 44$) of participants reporting that they had access. When

TABLE 3 Participants' access to assistive devices for lifting or moving patients and their self-reported confidence in using them.

Type of assistive device	Has access	Confident using
Hoyer life	41 (45.1)	24 (26.4)
Stand lift	31 (34.1)	19 (20.9)
Gait belt	44 (48.4)	38 (41.8)
Slide sheet	40 (44.0)	35 (38.5)

asked whether they felt confident in their ability to use assistive devices, a similar pattern was identified. Only 21% (n = 19) of participants indicated they were confident using stand assist devices, the lowest of the provided items. Just over a quarter of participants (n = 24) indicated that they were confident using Hoyer lifts, while 38.5% were confident using slide sheets. The highest confidence was reported with gait belts (n = 38, 41.8%).

3.2.2 | Observations of weight stigma: Qualitative findings

Responses to the prompt, "Please elaborate on how clinical observations have impacted your feelings about caring for patients of a larger size" related to their observations of weight stigma behaviors were also analyzed. Three themes were identified: *apprehension or dread*, *guilt*, and *pushed toward advocacy*.

Apprehension or dread. This theme relates to the feeling of discomfort, distress, or angst related to caring for a patient in a large body and to anticipation of hearing/seeing weight stigma from healthcare professionals. One participant expressed apprehension and dread related to both, describing that the apprehension was a learned response based on seeing the reactions of healthcare professionals in clinical settings when they care for patients in larger bodies.

> I feel that others' negativity about caring for patients makes me have feelings of dread for also caring for them. They describe it as being such a negative experience so I start to also view it that way. It also makes me uncomfortable and I dread having to respond to comments where they clearly want me to join in judging the patients' habits etc.

Guilt. This theme was characterized by participants expressing their feelings of sadness or regret from personal biases, overheard conversations, or observed mistreatment toward people in larger bodies. Participants expressed feelings of guilt related to their past behavior toward patients in larger bodies and also because of their experiences as bystanders when healthcare professionals engaged in weight stigma behaviors.

> I feel really guilty looking at the stuff that I've done because I feel like I know better than to do it. A lot of the time I find myself just agreeing with whatever my preceptor or coworkers are saying because I don't want to start anything. I want to do a better job but I don't know how to without alienating myself.

Pushed toward advocacy. This theme described how participants felt driven to act on behalf of patients in larger bodies to protect them but also driven to advocate on behalf of themselves for needed resources. One participant described how a previous observation of weight stigma caused her to seek out accountability.

> I think that experience will live with me for the rest of my career. My peers and I immediately submitted a complaint about the nurse, because her actions toward the pt [patient] were unacceptable. No matter the size or mental status of a pt [patient] privacy and respect should be given.

4 | DISCUSSION

The present study aimed to evaluate the types of weight stigma observed by pre-licensure nursing students and recent graduates during their clinical experiences and to determine their preparedness to provide respectful care to people in larger bodies. Results showed that a quarter of participants personally engaged in at least one weight stigma behavior, which could be related to the high level of weight bias observed in over half the sample. This sample had a higher level of high weight bias than other studies, which had found that nursing students mostly indicated either low weight bias or positive attitudes toward people in larger bodies.[23–27] This could be due to differences in scales used to measure weight bias between the studies. It could also be related to the characteristics of this sample. For example, the participants in the present study sample were relatively young (80% were under 25 years old) and approximately half were in their second year of nursing school. Previous studies have shown that as age increases[28] and as students progress through their nursing programs, weight bias tends to decrease.[24]

When asked about weight stigma behaviors observed while working with multiple healthcare professionals, approximately 19% observed their clinical instructors engaging in at least one weight stigma behavior. A quarter of participants described observing providers or other healthcare professionals also engaging in at least one weight stigma behavior. However, when asked about their observations of nurses or nursing assistants, one-third of the participants described observing at least one weight stigma behavior. The higher proportion of weight stigma behaviors observed by participants while working with nurses or nursing assistants could be explained by the amount of time students or recent graduates spend with this healthcare professional role relative to others. Greater time spent with a particular role means greater opportunity to observe weight stigma behaviors. Clinical instructors also work closely with students, although their role varies depending on setting, circumstances, and unit culture, but they may take a more indirect role in patient

interactions. Subsequently, this provides fewer opportunities for weight stigma to be observed. However, it is important to note that almost 17% of participants reported that they observed weight stigma behaviors from all healthcare professional roles (i.e., clinical instructors, nurses/nursing assistants, and providers/other healthcare professionals). While weight stigma has been described among all members of the healthcare team in broader research on the topic,[3] nurses and advanced practice providers (e.g., physicians, nurse practitioners) are the roles most frequently studied and have been observed engaging in weight stigma behaviors.[13,29]

When participants were asked to provide examples of factors that affected their comfort in caring for patients in larger bodies, they described two themes with a notable overlap: *fear of injury* and *resource challenges*. Structural inadequacies in clinical settings, such as understaffing or uncharged bariatric hospital beds, contributed to concerns that they, or their patients, would become injured while assisting or transferring patients in larger bodies. At least half of the participants indicated that they lacked access to assistive devices, such as gait belts or Hoyer lifts, and fewer felt confident using them. The lack of key infrastructure and staffing creates an environment where members of the healthcare team are placed at odds with patients, misplacing blame for their fear of injury toward the patient instead of toward the institutions where resources are constrained.[30–32] This dynamic was further exemplified when participants elaborated on their discomfort caring for patients in larger bodies and described how they observed *patients viewed as a burden* by healthcare professionals, something to be endured or perceived as extra tasks to be completed. It is within this environment that nursing students are being socialized to their professions as future RNs and will continue coping with structural inadequacies that place them in conflict with patient needs.

Overall, a significant proportion of participants report that observations of weight stigma in clinical rotations, which are intended to prepare them for caring for patients as nurses, affect their feelings of caring for people in larger bodies and their perceived ability to provide respectful care. Approximately 28% of participants reported that observing healthcare professionals engage in weight stigma behaviors made them feel less able to provide respectful care to patients in larger bodies. One-third described observations of weight stigma as affecting their personal feelings toward patients with larger bodies. When asked to describe how their feelings were affected, participants described a theme of *apprehension or dread*, which some participants attributed to concerns about how other healthcare professionals will perceive them if they do not participate in weight stigma behaviors, such as laughing about a patient in a large body or discussing their need to lose weight. They described a risk of being ostracized if they spoke against these behaviors. Participants also described a theme of *guilt* related to their behavior toward these patients but also described feeling *guilt* for not speaking up to stop weight stigma behaviors that they observed. A previous study that tested an education intervention using weight sensitivity training to reduce weight bias found that post-intervention nursing students also showed *guilt* or remorse for their assumptions, and behavior toward people in larger bodies.[33] It is possible that these feelings arose as a result of participating in this study, as the participants were asked to reflect and engage with their experiences and previous behavior. Participants also described how negative feelings from observations of weight stigma also led to the theme *pushed toward advocacy*. Students described instances where they sought to address mistreatment that occurred and advocated for their own needs as well. In these examples provided, students showed receptiveness to challenging norms and moved toward a healthcare environment that centers on patient needs instead of *blaming* and shaming patients in larger bodies. Interventions that build empathy and educate healthcare professional students are effective tools to reduce weight bias, although the authors emphasize that these interventions should be coupled with mentorship that reinforces inclusive and respectful behaviors in clinical settings.[20] There has been a rise in the use of simulation to educate students on weight bias and increase empathy.[20,34] This intervention could be an opportunity to develop students' feelings of empowerment and responsibility to advocate for patients by providing scenarios where weight stigma behaviors by other healthcare professionals are observed and students are mentored through the experience. Clinical instructors, who were the healthcare professional role least often observed by participants to engage in weight stigma behaviors, play a key role in integrating such opportunities into simulation and clinical settings.

This study is among the first to examine role modeling and socialization in clinical settings as a potential exposure to weight stigma and to evaluate the healthcare professional role that was observed by nursing students. Furthermore, this study evaluated the perceived impact these observations had on students' ability to provide respectful care to people in larger bodies. This knowledge is important as it can inform what types of interventions are needed and where the greatest areas of opportunity are to reduce weight bias and weight stigma. However, it is important to note that the present study has some notable limitations. The small convenience sample was largely homogeneous, mostly women who were white and located in the northeastern US and described their body weight/size as average. The sample was also primarily current students enrolled in a 4-year pre-licensure program. Therefore, these findings may not be generalizable to the general population of nursing students and recent graduates. The use of the Fat Phobia Scale in the present study may introduce challenges to the internal validity of the findings as there are scales that have been well validated and are more consistently used in previous studies, such as the Anti-Fat Attitudes Questionnaire and the Attitudes Toward Obese People.[2] Lastly, the measurement of the healthcare professional role and the type of weight stigma observed provided some information, but it does not communicate the frequency, severity, or the setting where each type of weight stigma was observed. For example, a greater proportion of students observed nurses and nursing assistants engaging in weight stigma behaviors, but the frequency or severity of those behaviors could be greater in another healthcare professional roles.

Areas for future study should include longitudinal evaluation of nursing students' weight bias and weight stigma that follows them

through some portion of their post-licensure practice to better understand the role of various weight stigma exposures, such as curriculum, clinical socialization, or other contextual factors. An important aspect of our findings is also the relationship between the themes of *fear of injury*, *resource challenges*, and *patient viewed as a burden*. Research that incorporates an evaluation of resource availability and its relationship with weight bias stigma can expound on these findings through a systems-level approach. These findings point to the potential that future weight bias intervention development can be meaningfully advanced by the development of a multilevel approach that integrates curriculum, clinical, and structural resource components.

AUTHOR CONTRIBUTIONS

Kristen D. Clark and Myah Kerbyson contributed to the conceptualization of the study, methodology, formal analysis, investigation, data curation, and writing of the original draft. Kristen D. Clark contributed to project administration, supervision of the study, and validation. All authors contributed to the writing, review, and editing of the final draft and approved of the final submitted work.

ACKNOWLEDGMENTS

We wish to extend our appreciation to Emily Roy, Alyssa O'Brien, and Kerry Nolte for their dedicated collaboration on this research project. Their enthusiastic engagement, insightful contributions, and shared commitment to excellence were greatly appreciated. There are no sources of funding for this work.

CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

ORCID

Kristen D. Clark https://orcid.org/0000-0001-6584-4560

REFERENCES

1. Lacroix E, Alberga A, Russell-Mathew S, McLaren L, von Ranson K. Weight bias: a systematic review of characteristics and psychometric properties of self-report questionnaires. *Obes Facts*. 2017;10(3):223-237. https://doi.org/10.1159/000475716
2. Stewart SJF, Ogden J. What are weight bias measures measuring? An evaluation of core measures of weight bias and weight bias internalisation. *Health Psychol Open*. 2021;8(2):20551029211029149. https://doi.org/10.1177/20551029211029149
3. Lawrence BJ, Kerr D, Pollard CM, et al. Weight bias among health care professionals: a systematic review and meta-analysis. *Obesity*. 2021;29(11):1802-1812. https://doi.org/10.1002/oby.23266
4. Puhl RM, Himmelstein MS, Pearl RL. Weight stigma as a psychosocial contributor to obesity. *Am Psychol*. 2020;75(2):274-289. https://doi.org/10.1037/amp0000538
5. Ryan L, Coyne R, Heary C, et al. Weight stigma experienced by patients with obesity in healthcare settings: a qualitative evidence synthesis. *Obes Rev*. 2023;24(10):e13606. https://doi.org/10.1111/obr.13606
6. Phelan SM, Burgess DJ, Yeazel MW, Hellerstedt WL, Griffin JM, van Ryn M. Impact of weight bias and stigma on quality of care and outcomes for patients with obesity. *Obes Rev*. 2015;16(4):319-326. https://doi.org/10.1111/obr.12266
7. Alberga AS, Edache IY, Forhan M, Russell-Mayhew S. Weight bias and health care utilization: a scoping review. *Prim Health Care Res Dev*. 2019;20:e116. https://doi.org/10.1017/S1463423619000227
8. Kline KM, O'neill EA, Behar S, Winter VR, Clemens JP. Weight stigma: a potential barrier to psychiatric/mental health medication care. *Soc Work Ment Health*. 2023;21(5):492-509. https://doi.org/10.1080/15332985.2023.2184191
9. Byrd R, Dolbier C, Whited M, Carels RA. The role of weight stigma in health care avoidance and mistrust among pregnant women. *Stigma Health*. 2023. https://doi.org/10.1037/sah0000481
10. Bidstrup H, Brennan L, Kaufmann L, de la Piedad Garcia X. Internalised weight stigma as a mediator of the relationship between experienced/perceived weight stigma and biopsychosocial outcomes: a systematic review. *Int J Obes*. 2022;46(1):1-9. https://doi.org/10.1038/s41366-021-00982-4
11. Wu YK, Berry DC. Impact of weight stigma on physiological and psychological health outcomes for overweight and obese adults: a systematic review. *J Adv Nurs*. 2018;74(5):1030-1042. https://doi.org/10.1111/jan.13511
12. Health Organization. Nursing and midwifery. 2022. Accessed March 14, 2024. https://www.who.int/news-room/fact-sheets/detail/nursing-and-midwifery
13. Smiley RA, Allgeyer RL, Shobo Y, et al. The 2022 National Nursing Workforce Survey. *J Nurs Regul*. 2023;14(1, suppl 2):S1-S90. https://doi.org/10.1016/S2155-8256(23)00047-9
14. Butler R, Monsalve M, Thomas GW, et al. Estimating time physicians and other health care workers spend with patients in an intensive care unit using a sensor network. *Am J Med*. 2018;131(8):972.e9-972.e15. https://doi.org/10.1016/j.amjmed.2018.03.015
15. Oliver TL, Qi BB, Diewald LK, Shenkman R, Kaufmann PG. Development of a weight bias reduction intervention for third-year nursing students. *Clin Obes*. 2022;12(2):e12498. https://doi.org/10.1111/cob.12498
16. Oliver TL, Qi BB, Shenkman R, Diewald L, Smeltzer SC. Weight sensitivity training among undergraduate nursing students. *J Nurs Educ*. 2020;59(8):453-456. https://doi.org/10.3928/01484834-20200723-06
17. Gajewski EM. Effects of weight bias training on student nurse empathy: a quasiexperimental study. *Nurse Educ Pract*. 2023;66:103538. https://doi.org/10.1016/j.nepr.2022.103538
18. Herrmann-Werner A, Loda T, Wiesner LM, Erschens RS, Junne F, Zipfel S. Is an obesity simulation suit in an undergraduate medical communication class a valuable teaching tool? A cross-sectional proof of concept study. *BMJ Open*. 2019;9(8):e029738. https://doi.org/10.1136/bmjopen-2019-029738
19. Bacon JG, Scheltema KE, Robinson BE. Fat phobia scale revisited: the short form. *Int J Obes*. 2001;25(2):252-257. https://doi.org/10.1038/sj.ijo.0801537
20. Moore CH, Oliver TL, Randolph J, Dowdell EB. Interventions for reducing weight bias in healthcare providers: an interprofessional systematic review and meta-analysis. *Clin Obes*. 2022;12(6):e12545. https://doi.org/10.1111/cob.12545
21. Stata C. Stata statistical software: release 15. 2017.
22. Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol*. 2006;3(2):77-101. https://doi.org/10.1191/1478088706qp063oa
23. Allnutt AE, Smith DJ, Torrence WA, Alexander DS. Examining weight bias attitudes and obesity beliefs among undergraduate students. *J Am Coll Health*. 2022:72(6):1814-1819. https://doi.org/10.1080/07448481.2022.2093114
24. de los Angeles Rodríguez-Gázquez M, Ruiz-Iglesias A, González-López JR. Changes in anti-fat attitudes among undergraduate nursing students. *Nurse Educ Today*. 2020;95:104584. https://doi.org/10.1016/j.nedt.2020.104584

25. Gormley N, Melby V. Nursing students' attitudes towards obese people, knowledge of obesity risk, and self-disclosure of own health behaviours: an exploratory survey. *Nurse Educ Today*. 2020;84:104232. https://doi.org/10.1016/j.nedt.2019.104232
26. Ozaydin T, Kaya TMM. An investigation of the prejudice and stigmatization levels of nursing students towards obese individuals. *Arch Psychiatr Nurs*. 2022;40:109-114. https://doi.org/10.1016/j.apnu.2022.06.002
27. Yılmaz HÖ, Yabancı Ayhan N. Is there prejudice against obese persons among health professionals? A sample of student nurses and registered nurses. *Perspect Psychiatr Care*. 2019;55(2):262-268. https://doi.org/10.1111/ppc.12359
28. Darling R, Atav AS. Attitudes toward obese people: a comparative study of nursing, education, and social work students. *J Prof Nurs*. 2019;35(2):138-146. https://doi.org/10.1016/j.profnurs.2018.07.009
29. Turner SL. Pediatric healthcare professionals' attitudes and beliefs about weight stigma: a descriptive study. *J Pediatr Nurs*. 2024;75:64-71. https://doi.org/10.1016/j.pedn.2023.12.010
30. Hyer S, Conner NE. Concept of overweight bias among healthcare professionals: an evolutionary concept analysis. *Nurs Forum*. 2020;55(3):395-402. https://doi.org/10.1111/nuf.12442
31. Oliver TL, Shenkman R, Diewald LK, Dowdell EB. Nursing students' perspectives on observed weight bias in healthcare settings: a qualitative study. *Nurs Forum*. 2021;56(1):58-65. https://doi.org/10.1111/nuf.12522
32. Robstad N, Söderhamn U, Fegran L. Intensive care nurses' experiences of caring for obese intensive care patients: a hermeneutic study. *J Clin Nurs*. 2018;27(1–2):386-395. https://doi.org/10.1111/jocn.13937
33. Barra M, Singh Hernandez SS. Too big to be seen: weight-based discrimination among nursing students. *Nurs Forum*. 2018;53(4):529-534. https://doi.org/10.1111/nuf.12282
34. Oliver TL, Furman GE, Shenkman R, Diewald LK, Brace M, Mariani B. Cultivating inclusivity: a pilot study utilizing simulation-based approaches for weight bias mitigation. *Clin Simul Nurs*. 2024;91:101551. https://doi.org/10.1016/j.ecns.2024.101551

How to cite this article: Kerbyson M, Clark KD. Clinical observations of weight stigma among nursing students: A descriptive approach. *Obes Sci Pract*. 2024;e70008. https://doi.org/10.1002/osp4.70008