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Self-reflection: Relationship Building in Patients With Excess Weight

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ABSTRACT

Obesity or excess weight is a well-documented health problem. Obesity bias is prevalent in society, and literature suggests obesity bias exists among health care providers. This article addresses the bias and stigmatization associated with weight and outlines ethical principles for nurse practitioners caring for vulnerable populations such as the obese. Self-reflection, a key method to address potential provider obesity bias, is outlined through use of the Johns Model for Structured Reflection.

Keywords: cultural safety, ethical principles, Johns Model for Structured Reflection, obesity bias

Nurse practitioner (NP) clinicians are in a unique position to hear sensitive details of an individual's life, including those surrounding weight. Many patients encountered in primary and specialty care are frustrated with their weight and would benefit from interventions offered by the health care team. Weight, however, can be a difficult topic to discuss during appointments for a variety of reasons—including patient and health care provider factors. Patient-related factors include worry about blame, privacy, socioeconomic constraints (food, exercise facilities/equipment, medication/co-pay costs), and insufficient social support.[1,2] Time constraints, clinician skepticism, clinician confidence relating to diagnosis and management, and even personal bias against those with obesity are contributing health care provider factors.[3,4] The lack of an established therapeutic caring-trusting relationship could also significantly affect an NP's ability to effectively intervene.

Given the prevalence of overweight and obesity among industrialized countries, health care providers must become comfortable offering weight-related assistance. The purpose of this report is to discuss clinician self-reflection regarding attitudes, acceptance, and comfort caring for individuals with obesity or excess weight, and the related ethical underpinnings specifically related to the nursing profession. Assessing and understanding values and beliefs that manifest as attitudes is a start toward change. Ultimately, as clinician insights are discovered, and tensions addressed through reflection, the development of a therapeutic caring-trusting relationship can begin. Once an individual patient perceives authentic caring, then the evidence-informed interventions, as outlined in obesity clinical guidelines, can begin.[5]

BACKGROUND

Physical comorbidities associated with obesity are well documented and include cardiovascular disease; endometrial, pancreatic, kidney, breast, and colon cancers; type 2 diabetes; osteoarthritis; asthma; gall bladder disease; chronic back pain; and liver steatosis.[6,7] Psychologically, obesity, with its related body image disturbance, is associated with reduced self-esteem, shame, and depression.[8-11]

In addition to personal physical and psychological manifestations, individuals with obesity often experience social stigmatization and bias from others.[1,12,13] Such stigmatization and bias is present in the media, health care settings, seating environments, terminology used, and even in the professional literature.[12-16] The American Psychological Association and American Medical Association writing styles are now recommending a "people first" approach to journal writing, in addition to avoiding terminology consistent with victimization—such as "suffering from."[17,18] Qualitative research by Wadden and Didie found that, although no term depicting excess weight is highly desirable among obese individuals, "weight" was the term most positively accepted.[19] Unfortunately, "weight" alone

lacks specificity. Therefore, "excess, or excessive weight," a term found to be neutral in Wadden and Didie's study, is adopted herein for this study.[19]

ETHICS AND VULNERABLE POPULATIONS

By virtue of the potential for stigmatization and bias, in addition to increased risk for poor long-term health associated with excess weight, persons with excessive weight could be considered a vulnerable population. Garcel et al. defined vulnerable populations as groups or individuals "who, due to a wide variety of factors, are at a greater risk for poor health status and health care access."[20(p7)] In addition, they outline the convergence of a variety of factors in an individual's life such as physical, mental, and/or social factors, whereby altered health status along one dimension contributes to altered health status in the others.[20] Thus, excessive weight could be a major factor in several coexisting biopsychosocial vulnerabilities.

Caring for and commitment to vulnerable populations are central concepts in nursing.[21] Such care is emphasized in the recently revised American Nursing Association (ANA) Code of Ethics whereby the nurse, which includes all levels of professional nursing, is in a nonnegotiable position to practice in a manner respecting the "inherent dignity, worth, and unique attributes of every person."[21] Promotion of social justice, another tenet within the ANA Code of Ethics, dealing with the "marginalized…exploited, and voiceless" is another parallel concept that can be applied to individuals with excess weight due to the tendency toward social isolation.[21]

Ethical care is universally important to all vulnerable or marginalized populations—whether related to excess weight or another situation. Recent international professional nursing literature has also addressed these concepts. Developed in New Zealand, the concept of culturally safe care addresses the power imbalances between clinicians and patients, particularly vulnerable or marginalized persons.[22] New Zealand's nursing council specifically states that a nurse's practice is unsafe if it "demeans or disempowers…the well-being of an individual."[23] The council also promotes the process of self-reflection as part of this culturally safe, ethical nursing care.[23] A power imbalance can exist when the NP, especially if of normal weight, holds position over the vulnerable patient with excessive weight. This circumstance deserves acknowledgment and subsequent reflection.

Patients have a right to unbiased care. Dr. Peter Attia bravely began a social media dialogue as a provider with an excess weight bias.[24] Attia discussed a personal struggle with contempt toward a woman requiring an amputation due to complications of diabetes.[24] Excessive weight, as is often the case, was a factor contributing to the patient's uncontrolled diabetes. Attia assumed the patient's excessive weight was related to overindulgence with food and lack of physical activity, and subsequently assigned the patient blame for the pending amputation.[24] During a meaningful reflection, Attia recalled earlier training in medical research whereby the challenge was to question all assumptions.[24] Then, in a transformative moment, he challenged himself against making assumptions regarding the etiology of a patient's excess weight, and instead pledged to provide such patients with the same compassionate care as individuals of normal weight.[24]

Dr. Attia's example illustrates how clinician bias interferes with respect and appreciation for an individual's worth or unique attributes. In such cases, authentic caring is compromised and the individual is demeaned. Therefore, an important first step in the process of caring for persons with excessive weight gain is self-reflection.

MODEL FOR STRUCTURED REFLECTION

The practice of self-reflection is imperative in developing compassion toward all vulnerable populations, including those with excessive weight gain. British reflective practice expert, Christopher Johns, defines reflection as "being mindful of self, either within or after an experience…in order to confront, understand, and move towards resolving contradiction between one's vision and actual practice."[25] Johns has drawn a distinction between describing a situation versus reflecting upon the same. A description is defined as "the raw data of experience," whereas reflection goes beyond the facts, helping a committed nurse "counter negative qualities…associated with defensiveness…resistance and ignorance," and experience transformative insight, which could ultimately improve the nurse-patient therapeutic relationship.[25]