

**PERCEPTIONS OF HOSPITALIZATION:
A QUALITATIVE STUDY
OF PEOPLE WHO ARE MORBIDLY OBESE**

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ABSTRACT

This qualitative research study explored the perceptions associated with acute hospitalization of individuals defined as morbidly obese. Interviews were one-on-one and utilized a semi-structured design. Nine participants, six females and three males were interviewed. Questions were aimed at exploring individuals' personal hospital experience and their perceptions associated with care and treatment during their admission. Narratives shared indicated that participants did not feel slighted because of their anthropometrics and that everyone receives the same basic level of care. Most participants accepted the processes and policies of the hospital as "the way it is." The concerns are systemic and overall change is warranted. The data collected provides not only an understanding of the challenges faced in hospital, but also the daily obstacles encountered and how this impacts public health.

KEYWORDS: Obesity, Hospitalization, Acute Care.

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CHAPTER 1: INTRODUCTION

1.1 Obesity: Definitions and Causes

The word obesity is a medical term recognized by the World Health Organization (WHO, 2014) and is defined as having a body mass index (BMI; kg/m^2) over 30 for males and females over the age of 20 years. Obesity is further divided into three classes including Class III ($\text{BMI} \geq 40 \text{ kg/m}^2$) which is also described as morbid obesity. Obesity significantly increases the risk for hypertension, dyslipidemia, type 2 diabetes mellitus, coronary heart disease, sleep apnea and chronic joint pain (e.g., Formiguera & Canton, 2004; Haslam, 2005). Many visits to the doctors' office are due to these obesity related health problems (Spence-Jones, 2003). The term 'obesity epidemic' is often used to describe the increasing rates of obesity during the 20th century. Indeed, according to Shields, Carroll and Ogden (2011) and the Canadian Health Measures Survey (CHMS) in 2007-2009 the prevalence of obesity in Canada was 24.1% and was even higher in the United States at 34.4%.

Bariatrics is the branch of medicine that deals with the causes, prevention, and treatment of obesity (WHO, 2014). According to the WHO, obesity is caused by excessive caloric intake combined with sedentary activity. Thus, the treatment of obesity has primarily focused on individual behaviour change and medical treatments (Puhl & Heuer, 2009). However, recent perspectives suggest that obesity cannot be placed solely at the individual level. Recent perspectives suggest that obesity is best understood from an ecological perspective (i.e., taking into account the entire ecological system involving the dynamic interactions between personal and environmental factors; Bronfenbrenner,

1986; Glanz, Lewis, & Rimer, 1997) involving four major considerations: 1) the individual; 2) the environment; 3) society (cultural) and 4) political systems. From the individual perspective there are genetic influences that contribute to variation in BMI through differences in resting metabolic rate, body fat distribution and weight gain related to over feeding (e.g., Spence-Jones, 2003). Environmentally, spaces which allow for social interaction with peers or engagement in activities of daily living are not designed to accommodate larger individuals (Forhan, Law, Vrkljan & Taylor, 2010). Socially, persons who are obese are viewed as lazy and less competent conscientious, which translates into constraints within areas of life such as employment, leisure, social participation, and health care (Puhl & Heuer, 2008, 2010; Puhl, Schwartz & Brownell, 2005; Spence-Jones, 2003). Social and cultural factors contribute to obesity with an increase in sedentary jobs, the proliferation of modern technology, increased use of motor vehicles and the availability and promotion of convenience foods (Puhl & Heuer, 2010). Finally, the political aspect of obesity involves the institutional and legal framework of health preventative approaches (e.g., lack of funding, coordination between stakeholders and implementation of prevention in the health care system) (Hilbert et al., 2007). This multi-level perspective furthers the understanding of the complexity of adult obesity this condition and can help inform public-health strategies on the prevention of this condition. While the prevention and treatment of obesity are the ultimate goals, it is still important to consider the quality of life, treatment of secondary health issues and self-management of individuals who are currently obese. There is continued need to positively affect the lives of those who struggle with this health issue while facing the stigma that is associated with being obese not only in terms of health but in all facets of life. The remainder of this

introduction will focus on stigma and discrimination which are prominent in the literature and will provide the purpose of the study.

1.2 Stigma and Anti-Fat Bias

Stigma and discrimination toward people who are obese is predominant in North American society (Puhl & Heuer, 2010). Harmful weight based stereotypes exist suggesting that those who are obese are unintelligent, noncompliant and lack will power (Puhl & Heuer, 2010). Weight stigma is a social problem that is largely ignored and justified as a personal failing (Puhl & Heuer, 2010). This personal responsibility for obesity is what fuels anti-fat attitudes (Puhl, Schwartz & Brownell, 2005). It has been reported that these attitudes, stigma and discrimination impact many areas of life among persons who are obese, particularly those viewed as morbidly obese, including work, education, interpersonal relationships, health and access to health care (Puhl & Heuer, 2008, 2010; Spence-Jones, 2003).

1.2.1 Obesity Stigma and Discrimination in Health Care

Although health professionals are the ones who can help with obesity management and prevention, they are often the ones contributing to the health disparity due to stigma and discrimination (Puhl & Heuer, 2010). Obesity is often dismissed as a personal failing so it is not treated on par with non-stigmatized medical conditions (Huizinga, Copper, Bleich, Clark & Beach, 2009). For example, research indicates that providers spend less time in appointments and provide less education to people who are obese compared to thinner patients (Shiffman et al., 2009). Because of actual or perceived discrimination, individuals with obesity often do not address their weight

concerns with providers and are less likely to undergo age-appropriate screenings for certain diseases (Puhl & Heuer, 2010). Care is delayed not only because of discrimination from providers but also because of inappropriate and inadequate medical equipment and resources (e.g., examination tables are too small for body size) (Puhl & Heuer, 2010). According to Epstein and Ogden (2005), general practitioners do not appreciate the seriousness of obesity as a health issue and therefore may not fulfill their roles in obesity management effectively. Epstein and Ogden also reported in their qualitative study of general practitioners views on obesity that although physicians believed that the management of obesity was the responsibility of the patient, the patient viewed obesity as a medical problem that should be managed by the physician; this contrast in attitudes could lead to disparities in care. There remains a lack of confidence among physicians in providing advice on individual behaviour change (e.g., increased exercise, prescription of a diet plan) as many physicians remain skeptical about the patient's abilities and the efficacy of weight loss interventions (Epstein & Ogden, 2005; Shiffman et al., 2009).

Outside of the general practitioner's office there are other health care professionals that affect the management and quality of care of those with obesity. These professionals are frequently encountered during hospitalization as persons with obesity often fail to access care before it is necessary (i.e., acute conditions become chronic requiring hospitalization) (Merrill & Grassley, 2008). In a hospital setting there are many health professionals that a person with obesity may encounter including nursing, dieticians and therapists (e.g., physical, occupational and recreation therapies). Foremost in acute care, patients' admitting diagnosis is often treated rather than the underlying

cause; thus obesity goes unmanaged (Jefferey & Kitto, 2006). Nursing research shows that the obese person is often reduced from a whole person, to a discounted one, whose behaviors are viewed as deviant. The provision of holistic nursing; the emotional, psychosocial, spiritual and physical aspects of care are challenged and the biomedical model dominates when caring for a patient with obesity (Jefferey & Kitto, 2006). The care of person's with obesity is seen as stressful and physically demanding by nurses and the patient is viewed as unattractive, lazy and lacking in self-control (Poon & Tarrant, 2009).

Although dietitians are considered to be important providers of weight management advice, there is limited research regarding dietitians' attitude toward the patient with obesity. Puhl, Wharton, and Heuer (2009) for example stated that dietitians were not immune to weight bias; with some clinicians reporting obese individuals' weight status as a result of their emotional issues and stereotyping obese individuals as unintelligent and dishonest. Therapists (physical, occupational and recreation) can also play a role in weight management through activity programs and environmental accommodations; however, literature is limited and results are inconclusive with regard to attitudes and roles toward obesity treatment and management (Sack, Radler, Mairella, Touger-Decker & Khan, 2009). Just as the causes of obesity are multifactorial so too are the treatments. The only way to address this growing problem is for all health care professionals to unite and utilize every opportunity to educate patients and society (Hamdy, 2010). The topics of stigma towards persons with obesity will be fully explored in Chapter 2: Literature Review.

1.3 Study Rationale

The area of obesity and bariatrics is an emerging field with research focusing primarily on weight stigma amongst the adult population. As with any new area of research there are gaps in content and design or methodology. Limitations in understanding obesity exist including its causes and treatments as well as how obesity impacts the lives and experiences of people with obesity.

During hospitalization the acute problem not the underlying cause or chronic condition is treated (Jefferey & Kitto, 2006). Wagner et al. (2001) recommended that a chronic care model needs to be developed for the proper management of obesity and that “fitting into” the current acute care model is not the answer to addressing the prevention and treatment of obesity. Further research in acute, clinic, outpatient and primary care is also recommended in the literature. According to Durso and Latner (2008) persons classified as obese are 40-50 % more likely to experience discrimination as a result of their weight status, with medical and health settings being one of many contexts in which stigmatization occurs. Clarification of the psychological and socio-demographic determinants of stigmatizing attitudes toward obesity is needed. Research that aims to understand these determinants may lessen the focus on personal controllability, increase awareness about the chronicity of obesity, increase awareness about the high prevalence of the condition and increase awareness of obesity as an illness/disease. If classified as an illness obesity may be more accepted and subsequently less stigmatized (Hilbert et al., 2008). To improve the well-being of persons with obesity, both physically and psychologically, it is critical to better understand the factors that exacerbate weight bias (Carels & Musher-Eizenman, 2010).

Patient-physician communication needs to be enhanced as it is critical for the provision of adequate care and treatment (Pulvers et al., 2008). Without a respectful relationship persons with obesity typically avoid health care visits (Huizanga et al., 2009). Just as variations in BMI may affect physician-patient relationships, it is suggested that health beliefs and behaviours of obese individuals themselves vary according to the severity of their obesity (Lewis et al., 2010). Understanding the socio-cultural and individual factors associated with these beliefs and behaviours is important for developing appropriate interventions and for developing population based messages to encourage change. Knowledge regarding the impact that the public focus on obesity has on individuals with obesity is needed; for example, are health and policy responses stigmatizing and disempowering people who are obese to address the health risks (Lewis et al., 2010)?

Plenty has been written on the discrimination toward the obese in multiple facets of life and the body of knowledge on obesity treatment and prevention continues to develop. However, little is known from the perspective of people with obesity themselves as research is lacking on the experience of individuals who are obese. Not only is it necessary to know the impact of obesity on the utilization of the health care system but it is also necessary to know the impact of care on the person. Without understanding the personal experiences of individuals with obesity, efforts to work with those who have obesity to help manage their condition may be minimally effective. Research is needed to understand how to work with and care for this population within both primary and acute health care: How can we understand the hospital experiences of person's with obesity so as to provide better treatment, encouragement and care?

Understanding people's experiences of hospitalization can only strengthen healthcare workers, designers and policy makers' capacity to provide a supportive environment. A supportive environment constitutes not only the physical space but the equipment, interactions and care. This study focused primarily on the latter aspect and in particular looked at the psychosocial quality of hospitalization from the patients' perspective.

1.4 Purpose of the Study

This qualitative study explored the experiences of persons' with obesity during hospitalization in acute care facilities in an urban centre in Atlantic Canada. According to Twells, Knight and Alaghebandon (2010), despite having one of the highest prevalence rates of obesity, research in this area in Canada is limited. Participants were patients 19 years of age or older who had been admitted to one of two hospitals within the last 12 months, with a BMI of 40 or greater (morbidly obese or class III obesity). The objectives of this study were as follows: (1) understand hospitalization through the eyes of a patient with obesity patient; (2) explore the factors that impact the lives of the obese patient in hospital and in daily life from the patient's perspective; and (3) explore the relationship between persons' with obesity and health care professionals from the patient's perspective. The aim of this study was to enhance understanding of the complexity of obesity and how individuals with obesity understand their health, treatment and place in society. The implications of an anti-fat, pro-thin western society were considered when looking at the data.

To explore perceptions of hospitalization, participants were asked questions about the challenges of being overweight, how they were treated by health professionals and if they received adequate care during their hospitalization in acute care. To effectively reach people with obesity it was important to be sensitive to all emotional, physical and psychological needs. The study was qualitative and involved open ended semi-structured face-to-face interviews. Qualitative methods were chosen as the purpose of the research was to gain understanding of human health and health behaviour, rather than provide objective measures which would have warranted quantitative methodology (Green & Thorogood, 2009). Data was collected to the point of saturation with nine participants interviewed. The data was transcribed and coded using thematic analysis.

1.5 Organization of Thesis

This is a manuscript style thesis consisting of two stand-alone but related chapters. To ensure this is a cohesive and coherent piece of work, there are three other chapters providing additional information. Chapter 1, the current chapter provides an overall introduction to the background, rationale and purpose of this study. Chapter 2 is a literature review of work in the area of obesity including stigma, perceptions of caring for persons with obesity from various health professionals and relevant theoretical frameworks. Chapters 3 and 4 were prepared for both this thesis and for future submission to peer reviewed journals. To integrate the concepts and ensure readability as separate manuscripts, overlapping content and sentences may exist. Chapter 3: Hospital Experiences of People with Obesity presents the primary data from the study as a submission for the journal *Qualitative Health Research*. This chapter focuses on health

and hospitalization of persons with obesity. Chapter 4: Leisure Pursuits of Persons with Obesity describes leisure interests of persons with obesity. Although not the primary focus of the research, this secondary theme was explored during the discourses with participants who described their participation and experience in leisure. Leisure is an important component of health and this data was prepared for the journal entitled *Leisure Sciences*. Chapter 5 presents a discussion and conclusion of the research project.

CHAPTER 2: LITERATURE REVIEW

This chapter presents the relevant literature related to this investigation of the factors related to and experiences associated with hospitalization among persons with obesity. It also presents theoretical perspectives and gaps in this area of research. The rationale is to gain an understanding of the larger person's experience in terms of attitudes from health professionals, access to treatment and equipment and adequacy of space; with the aim of deconstructing existing approaches to care and promoting equal treatment and access for all. Research in the areas of: (1) Theory on Obesity; (2) Stigma of Obesity; (3) Obesity Discrimination; (4) Hospitalization; (5) Health Professionals; and (6) Gaps will be discussed.

2.1 Theoretical Approaches to Understanding Obesity

Obesity and the marginalization of persons with obesity are complex issues. This section introduces some possible theoretical approaches to understanding obesity in terms of attitudes towards and perceptions and experiences of people who are obese with a focus on the health care setting. Multiple theories were discussed in the literature to explain the experiences of individuals with obesity depending on the situation and type of interaction including: 1) attribution theory; 2) social identity theory/ social/self-categorization theory; and 3) medical model.

2.1.1 Attribution Theory

The theory of attribution relates to how individuals attribute causes to events and behaviour; that is, the concept of controllability and responsibility (Fiske & Taylor, 1991;

Heider, 1958). Our attributions are significantly driven by our emotional and motivational drives. Attributions are classified along three causal dimensions: locus of control, stability and controllability (Fiske & Taylor, 1991; Heider, 1958; Weiner, 1986). The locus of control dimension has two poles: internal versus external locus of control. The stability dimension of Attribution Theory captures whether causes change over time or not. Controllability contrasts causes one can control, such as skill/efficacy, from causes one cannot control, such as aptitude, mood, others' actions, and luck (Weiner, 1986).

According to Attribution Theory, for the individual with obesity, if the cause is believed to be external, then they may not take personal responsibility for the condition and the associated health risks; if the cause is seen as controllable and internal then they could become the target of stigma (Fiske & Taylor, 1991; Heider, 1958; Hilbert, Rief, & Braehler, 2008). Attribution has been used to explain the difference between high and low achievers. According to attribution theory, high achievers approach rather than avoid tasks, whereas the low achiever will tend to avoid success related chores due to doubt in ability. This can be applied to individuals with obesity as efforts to lose weight may have failed in the past so they are demoralized and do not attempt again (Hilbert et al., 2008). The goal is envisioned as something that is not achievable based on previous efforts so it is avoided.

Individuals with obesity are the targets of negative stereotypes; as the excess weight is often attributed to internal, controllable causes (Hilbert et al., 2009; Puhl & Heuer, 2009). It is often believed that they lack self-discipline, are blamed for their excess weight and are socially disliked (Puhl & Heuer, 2010). This is in contrast to

external, uncontrollable causal factors. Conditions such as Alzheimer's for example (which are rated low on personal responsibility) are rated high on liking and elicit pity and intentions to help (Puhl & Heuer, 2010). Whereas "controllable" conditions like obesity receive low rates of helping tendencies and evoke high anger (Puhl & Heuer, 2010). When excess weight is associated with an internal cause, there is less support for intervention measures and a tendency towards discrimination (Hilbert et al., 2008). With the increasing prevalence of persons with obesity, the effects of stigmatization on mental and physical health and overall well-being may be detrimental (Hilbert et al., 2008). The need for education and general increase in public knowledge is necessary to destigmatize this growing issue. Classifying obesity as an illness not as a product of laziness could be an approach toward increased acceptance of this multifaceted condition (Hilbert et al. 2008; Wagner et al., 2001).

The concept of attribution has also been discussed through the examination of perceptual reliance. Carels and Musher-Eizenman (2010), define perceptual reliance as a factor of individual differences, which is the tendency to judge individuals based on physical appearance. As Puhl and Heuer (2010) and Hilbert et al. (2008) explained, prevailing societal attributions place blame on the individuals for their excess weight; viewing them as weak-willed. Those who place this blame stigmatize and have a tendency to judge the person based on physical appearance. Typically individuals who believe weight is controllable and are globally negative toward persons of size have a high perceptual reliance (Carels & Musher-Eizenman, 2010). That is the higher the BMI, the greater the dislike and the more negative the personality traits attributed to the person,

in comparison to someone with a low BMI, who is seen more positively and liked based solely on appearance.

From the literature it is evident that stigma toward the obese is increasingly apparent in society. Environmental, social and personal factors all contribute to the experiences of those with obesity. Attribution theory as discussed above is concerned with how individuals interpret events and how this interpretation relates to thinking and behaviour.

2.1.2 Social Identity Theory/Social/Self Categorization

According to Tajfel and Turner (1979), social identity is the portion of an individual's self-concept that is derived from perceived membership in a relevant social group. In society, individuals have their own beliefs and values systems that are a product of growth, development, influences and life circumstance. Typically however, one's values and actions are a function of a larger socially acceptable system or group. According to social identity and self-categorization theory, the way people categorize themselves and others (in terms of their social group memberships) has a powerful influence on how they interpret and respond to social phenomena (Tarrant, Dazeley & Cottom, 2009). Groups in general tend to have similar behaviours and experience similar emotions. Although groups are comprised of individuals, there is some depersonalization of the self and development of a self-perception that becomes interchangeable with that of the group. In general terms there are in-groups and out-groups and behaviour is said to be motivated by the need to secure a positive social identity (Tarrant et al., 2009). In nearly all aspects of life (i.e., interpersonal relationships, education, employment and health

care) people who are obese are targets of stigma (e.g., Carels & Musher-Eizenman, 2010; Puhl & Heuer, 2010).

The prevalence of weight discrimination in western society has been compared to racial discrimination (Carels & Musher-Eizenman (2010), especially amongst women with obesity who experience greater discrimination (Foss & Sundby, 2003; Hilbert, Rief & Braehler, 2008; Puhl & Heuer, 2009). Subsequently, the obese would be considered an out-group and thus may experience a lack of empathy from others (Tarrant et al., 2009). To investigate this concept of empathy and social categorization, Tarrant et al. (2009) conducted three experiments. The experiments involved testing the hypothesis that empathy will be experienced more strongly if a person is a member of an in-group rather than an out-group. Testing also explored whether empathy for out-group members could be encouraged by activating an in-group norm which prescribed this emotion for others; that is, if an in-group believes in helping those in need, empathy be elicited whether they are a member of a socially accepted group or not. Overall, Tarrant et al. (2009) found that empathy and helping intention was stronger for members of an in-group versus an out-group. Basically, according to the self-categorization theory, empathy is likely to be experienced when another person is perceived to be in need. To apply this to the population of persons with obesity - excess weight is seen as a product of laziness, lack of competence and lack of self-discipline (Puhl & Heuer, 2009). Therefore, support and help are not offered as the person with obesity is portrayed negatively and considered a member of an out-group. Also in the Western world the culture and mass media prefer the 'thin ideal' which serves only to perpetuate the negative stereotype of those who are overweight (Brown, 2006).

Similar to the self-categorization theory is the perceived social consensus model. This model suggests that stigma and stereotypes are a function of perceptions of other people's stereotypical and stigmatizing beliefs (Puhl et al., 2005). Sharing attitudes increases acceptance and security in social groups. Attitudes are influenced by groups and particularly by in-groups. For example, Brown (2006) discussed that nurses' attitudes toward persons with obesity reflected those of broader society; Puhl et al. (2005) similarly stated that contributing to the stigma was the negative portrayal of persons who had obesity in popular media. Again, due to the prevalence of obesity stigma in society, intervention to yield change has to be multi-faceted. Strategies must be directed not only at the individual, but toward society as well, as social groups serve to shape perceptions and beliefs.

2.1.3 Medical Model

Although models are not theories in the true sense of the definition, models are a way of thinking and organizing information (Neuman, 2007). Under the medical model, people are defined by their illness or medical condition. The model promotes a view of needing to be cured. According to Shah and Mountain (2007), the medical model involves a scientific process of observation, differentiation, recognizing and treating symptoms to identifying etiology and developing specific treatments. It is a reductionist, not a holistic approach, as is evident in the literature. For example, the heavier the patient the less time is spent with them, subsequently the less attention provided and less consideration of individualized treatments (Hebl & Xu, 2001). The stigma is one of individual failure (i.e. non-compliance and weak will) rather than of failure of society to

encourage healthy living. Care systems are organized to respond quickly and efficiently to acute illness and/or injury as it comes through the door (Wagner et al., 2001).

Therefore upon presentation, the immediate problem, not the chronic one of obesity is addressed (Wagner et al., 2001). Diabetes for example, is common amongst individuals who have obesity (Peeters et al., 2003). In our current care system, the diabetic emergency would be treated with a prescription, rather than management of the underlying cause - obesity. The patients' role is passive, with no support or intention for lifestyle change as the problem has been 'fixed' (Puhl & Heuer, 2010). Also the physician has reduced the emergency to physiological imbalance rather than a complex physiological, psychological and physical consequence (Puhl & Heuer, 2010).

Researchers suggest that the current systems of care need to change to properly manage the chronically ill (i.e., Wagner et al., 2001) in which people with obesity could be categorized. The treatment must be multifaceted and patients must have the knowledge to manage their condition. The patient and the physician must have a mutually understood care plan with continuous follow-up (Wagner et al., 2001).

The complexity of obesity lends itself to multiple explanations. In summary the theories demonstrate that obesity is seen as product of individual responsibility (attribution theory), socially there are fewer opportunities provided or those that are available are avoided (self-categorization theory), and the acute not the chronic factors of obesity are treated (medical model). There are many potential theoretical perspectives that can be taken when discussing the concept of obesity in healthcare and obesity in society. The underlying principle is that stigma and discrimination exist toward the obese exists in many facets of society including healthcare.

2.2 The Stigma of Obesity

The stigmas of obesity are ever present in multiple facets of daily life and are particularly prevalent in Western society (Puhl&Heuer, 2008, 2010; Puhl, Schwartz & Brownell, 2005; Spence-Jones, 2003). Weight bias is evident in health care practice, health care facilities, employment settings, educational institutions and environmental space (Puhl, Schwartz & Brownell, 2005). Puhl and Heuer (2010) stated that throughout history people vulnerable to disease have been blamed for their illnesses because they are viewed as immoral, unclean and lazy. Applied to today's society, stigmas remain problematic for public health due to numerous psychological and physical consequences. Stigmatization means the rejection and disgrace connected with what is viewed as a physical deformity and behavioural aberration (Cahnman, 1968). With respect to obesity, the stigmas create disparities and interfere with the implementation of prevention and management programs (Puhl & Heuer, 2010), thus efforts must increase to change the hostile societal environment (Puhl, Schwartz & Brownell, 2005). This section will discuss the existence of stigma in obesity.

2.2.1 Does Stigma Exist in Obesity?

Research has demonstrated that persons with obesity are often stigmatized because the issue of weight is believed to be within personal control (e.g., Hilbert et al., 2009; Puhl & Heuer, 2009, 2010). For example, the degree of empathy for a person with obesity, has been found to be significantly less than for someone with Alzheimer's; as this disease was deemed beyond the individuals' control (Puhl & Heuer, 2010). Experimental research similarly has shown that attitudes were improved and stereotypes

reduced when the complex etiology of obesity (including genetic and biological factors) was emphasized; whereas, negative stereotypes were prominent when personal responsibility was highlighted (Puhl, Schwartz, & Brownell, 2005).

According to Attribution Theory, as previously discussed, stigmatizing attitudes toward the obese may be based on the perspective of individual control and responsibility for the excess weight (e.g. inactivity and overeating) (Fiske & Taylor, 1991; Heider, 1958; Hilbert, Rief, & Braehler., 2008). These attitudes may be grounded in social ideologies but little is known about the other psychological and socio-demographic determinants of the obesity stigma (Hilbert et al., 2008). Hilbert, Rief and Braehler's (2008) study identified psychological and socio-demographic variables as potential starting points for stigma reduction. They conducted a cross-sectional quantitative telephone survey study using a random sample of 1000 German's in the general population. The German translation of the subscale Weight Control/Blame (WCB) from the AntiFat Attitudes test was used to measure stigmatizing attitudes toward obesity. Causal attributions of obesity were assessed through three scales: behaviour, environment and heredity. Support for obesity prevention was determined through agreement with statements on various prevention strategies such as healthy eating, exercise and restricting advertising. Results indicated neither agreement nor disagreement with stigmatizing attitudes overall as the mean WCB score was 3.01 (on a 5-point scale); indicating the sample had neutral attitudes towards obesity. Causal attributions of obesity to behaviour were positively associated with the mean WCB score ($r = 0.31$), whereas causal attributions of obesity to heredity and labeling obesity as an illness were significantly associated with less stigmatization. This means that the main determinant of stigmatizing

attitudes toward obesity was the belief that its onset is controllable, whereas if obesity was contributed to heredity, there was much less stigma. Post hoc analysis also showed causal attributions of obesity to the environment were significantly associated with causal attributions to behaviour ($r = 0.16$). This suggests that environmental factors were assumed to be within and not outside one's control. A regression equation was used to predict stigmatizing attitudes toward obesity, with greater predictors including less education, not considering obesity as an illness, older age and less association of obesity with heredity. Finally, greater WCB scores were associated with greater support for obesity prevention, meaning that the more people viewed obesity as an undesirable condition, the more they agreed that measures should be taken to prevent it. In conclusion, neutral response to stigmatization may have been a covert response, with actual judgment expressed when it is appropriate to do so and drawbacks are inconsequential. Casual attributions to individual behaviour or controllability were the most significant predictors of greater stigmatizing attitudes. Less stigmatizing attitudes were found when obesity was labeled as an illness or was associated with genetic factors. Overall, Hilbert et al. (2008) demonstrated that stigmatizing attitudes toward obesity are prevalent in society and addressing beliefs about controllability and explaining the medical sequelae are necessary to initiate destigmatization. These results however must be viewed carefully as random digit dialing (often yields over sampling of some groups and underrepresentation of others) was used, lower socio-economic groups were underrepresented and ethnicity, which has been found to moderate stigmatizing attitudes, was not included in this study.

Despite evidence that body weight is determined by a complex interaction of biological and environmental factors, obese people are blamed for being overweight (e.g., Huizinga, Copper, Bleich, Clark & Beach, 2009). The etiology of weight bias and ways to ameliorate this stigma are poorly understood. Prevailing societal stigmas toward obese people were studied experimentally by Puhl et al. (2005). University students were targeted as previous research had shown a strong anti-fat bias amongst younger people. Three experiments were conducted. In the first experiment it was hypothesized that positive attitudes from others would result in an individual changing their initial attitude to be consistent with the consensus feedback. Undergraduate students ($N = 60$) were given attitude measures (Obese Persons Trait Survey, Beliefs about Obese Persons Scale, Marlowe-Crowne Social Desirability Scale, Just World Scale and BMI) and a week later each participant received feedback according scale ratings along with random assignment to the positive ($n = 30$) or negative feedback ($n = 30$) groups. Participants who received more favourable consensus feedback reported more positive and less negative characteristics. It was therefore concluded that consensus information affects attitudes; that is, expressed attitudes can be modified by providing consensus information about the beliefs of others. For example, positive attitudes, as hypothesized, were related to beliefs that obesity is caused by factors outside of personal control (Puhl et al., 2005).

In the second experiment investigating stigma and stereotypes of people who are obese, Puhl et al. (2005) examined whether consensus information was more influential depending on whether it came from an out-group (i.e., community college students) or an in-group (i.e., Ivy League Students). Yale students ($N = 55$) were presented with favourable consensus information (i.e., information on beliefs toward obese people) from

either the out or in-group. Favourable consensus feedback had more influence when it came from an in-group than an out-group. Results supported the self-categorization theory, which proposes that individuals will perceive in-group members to possess more credible knowledge than out group members.

The consensus method was compared to four other attitude change methods in modifying attitudes toward obesity in Puhl et al.'s third experiment. Participants (200 university students) were assigned to one of five conditions: 1) in-group favourable consensus feedback scenario; 2) information regarding the true prevalence of traits among obese people; 3) reading a vignette regarding the environment and biological components (or uncontrollable) causes of obesity; 4) reading a vignette discussing the controllable causes; and 5) a control group. Results showed that favourable consensus information significantly increased positive traits and decreased negative traits (Puhl et al., 2005). That is providing information about the uncontrollable causes of obesity is not necessary to improve attitudes toward obese people, and providing people with favourable consensus or trait prevalence information may improve attitudes and lead to perceptions that obesity is caused by factors outside of personal control. Puhl et al.'s (2005) study shows that attitudes toward obese people are influenced by people's perceptions of the consistency of their attitudes with others. It is important to consider that samples in each of the experiments included only university students and self-report measures were used; therefore results cannot be generalized to the general population nor, is it certain if change in attitude would translate into concrete behavioural change (Puhl et al., 2005).

The research reviewed suggests obesity stigma is present in our society. However, it is unknown the extent to which stigmatizing attitudes result in actual

discrimination towards people who are obese. Assigning blame to the individual is one factor that contributes to obesity stigma. This blame may in part be due to our anti-fat, pro-thin western society which may also contribute to obesity discrimination.

2.3 Obesity Discrimination: AntiFat / ProThin

There is a notion that people get what they deserve and deserve what they get (Malahy, Rubinlich & Kaiser, 2009). This is evident in society with individuals with obesity who are socially disliked and are the targets of negative stereotypes (Hilbert et al., 2008). According to Carels and Musher-Eizenman (2010), weight bias is widespread and can lead to discrimination in many areas of life; that is persons with obesity are at a disadvantage. There is significant societal pressure to be thin, particularly for women (Schwartz & Brownell, 2008). However, the extent of anti-fat bias varies from person to person, with no clear reason for the differences.

Some research has been conducted to better understand weight bias and to investigate the correlation between anti-fat and pro-thin attitudes. Based on the premise of varying attitudes among individuals, Carels and Musher-Eizenman (2010) studied whether individual differences associated with anti-fat bias also revealed a preference for thinness. In this study, participants completed an online survey that involved rating of realistic figures (men and women with range of BMIs from 18.5 to 40) based on factors of dislike and personal attributes. It was hypothesized that people who had negative attitudes toward obese people and believed that weight is controllable would more likely negatively judge individuals with obesity and look more favourably upon thin individuals. Three hundred and eight young adults (62% female), recruited from undergraduate

psychology classes participated in the study. Participants were sent a link to one of four online surveys that were identical except for random order and appearance (i.e. hair colour) of the figures. The participants completed sets of ratings about eight figures (four men and four women); one set involved rating dislike of the figure, with a second set of ratings assessing personality traits using the Fat Phobia Scale (FPS; Bacon, Scheltema & Robinson, 2001). Participants also completed the Attitudes toward Obese Persons Scale, Crandall's Anti-fat Attitudes Scale Willpower subscale and the Perceptual Reliance Index. Results showed a strong association between individual differences and target ratings of known weight status. From the analysis it was also evident that the extent to which a person relied on perceptual information (such as appearance) in determining their attitude towards others impacted the degree to which negative evaluations of obese individuals were made (Carels & Musher-Eizenman, 2010). That is, people who make judgments towards others based on their appearance tend to view the overweight and the obese more negatively. Participants in the study who believed weight is controllable had more negative attitudes toward the figures, than those who felt that weight is not controllable. Besides the negative view of the obese figures, there was also a positive view of the personality attributes of the low normal weight individuals (BMI = 18.5) and in some of the figures with a BMI of 25 (which is actually overweight). This is consistent with actual judgment in society as nearly two-thirds of the American population has a BMI in the range of 25 (Carels & Musher-Eizenman, 2010). People with a BMI of 25 were seen as normal, not as overweight. Again the study demonstrated that weight bias exists and there is antifat-prothin culture in Western society. There were limitations to this study including limited age range and racial diversity of the study sample. Using

actual photographs may increase the ecological validity and a greater range in BMI between figures is recommended. Similar to what Hilbert et al. (2008) demonstrated in their research, the findings of this study could be used in the development of stigma-reducing interventions (Carels & Musher-Eizenman, 2010).

Fat phobia or publics' typical response to obesity is that of laziness and lack of motivation, with support provided in the form of standardized messages to all individuals with obesity: eat better, lose weight, and exercise (Puhl & Heuer, 2008, 2010; Puhl, Schwartz & Brownell, 2005; Spence-Jones, 2003). The antifat-prothin attitudes of the general population is an important field of study but it is equally if not more important to understand the attitudes, beliefs and behaviours of individuals with obesity themselves. However, according to Lewis et al. (2010) beliefs and behaviours of individuals with obesity differ depending on the severity of the obesity. Lewis et al. studied the experiences, attitudes and opinions of 141 Australians (105 female, mean age was 44.5 years, 60% had post-secondary education, 62% were classified as obese and 38% as severely obese) with a BMI \geq 30 using in-depth qualitative semi structured telephone interviews. Individuals with obesity described themselves as overweight or fat; they did not see their weight as an immediate health risk; believed their obesity was caused by social and environmental factors and weight loss was motivated by societal pressures to be thin. Whereas individuals with severe obesity did believe in the seriousness of their weight as an immediate health risk; used the term obese to describe themselves; felt personally responsible for their obesity and the health risks motivated them for weight loss. However, both people who were obese and severely obese stated that they were personally responsible for changing health behaviours and losing weight, and that failed

attempts were very discouraging and only decreased motivation (Lewis et al., 2010). In general the study showed that individuals with obesity avoid the societal stereotypes in reference to their weight, whereas those with severe obesity used the negative stereotypes to describe themselves and blamed themselves for their obesity (Lewis et al., 2010). With respect to personal health risk, patients with obesity, particularly the men, did not see their weight as a problem, whereas those persons with severe obesity felt urgency in addressing health outcomes. The differences in results are less clear with respect to the public focus on obesity: persons with obesity appeared to absorb the social and environment factors of obesity but placed little to no significance on the health risks, while those persons with severe obesity reported being at war with themselves. Findings of this study cannot be generalized as the participants were primarily older women and the sample was not reflective of cultural diversity. Overall it is evident that beliefs and behaviours can and do differ depending on the severity of obesity thereby, responses and care must be tailored to the individual to support behavioural change for reducing health risks (Lewis et al., 2010).

In conclusion there is evidence that obesity discrimination exists and it may at least partly be explained by an antifat – prothin bias. It is also common for those who exhibit negative bias toward the obese to have a corresponding positive attitude toward those who are thin. Research on the concept of anti-fat/pro-thin beliefs has found that societal stereotypes do exist and that some individuals with obesity internalize this stigma. What is unfortunate is that these attitudes are often based on appearance alone. Obesity discrimination can negatively affect many areas of life among persons who are obese, particularly those viewed as morbidly obese, including work, education,

interpersonal relationships, health and access to health care (Puhl & Heuer, 2008, 2010; Spence-Jones, 2003). The next two sections of the literature review will discuss research on health care and obesity with a particular focus on obesity discrimination in the health care sector.

2.4 Hospitalization and Obesity

Social problems of prejudice and discrimination toward obese individuals exist at work, in public and in interpersonal relationships, and continue throughout the lifecycle (Camden, Brannan & Davis, 2008). This bias and prejudice also exists in healthcare. Given the increase in obesity, a large number of patients with obesity are being admitted to hospital because of disease associated with or exacerbated by their weight (e.g., Howe, Wright, Landis & Kissule, 2010; Spence-Jones, 2003). Lengths of stay and subsequent health care costs are greater than normal weight individuals and there is also an increased risk of mortality (Howe, Wright, Landis & Kissule, 2010). However, obesity continues to be under-recognized and under-treated (Howe et al., 2010).

2.4.1 Documenting and Treating Obesity in Acute and Primary Care

To identify patient and healthcare provider characteristics that affect recognition of obesity on medical wards, Howe et al. (2010) conducted a needs assessment at John Hopkins Bayview Medical Center, using an observational cohort study. The study involved review of the admission notes of 276 patient charts for documentation of obesity and/or intervention for obesity. Associations between provider and patient demographics and the documentation of obesity were statistically analyzed. There was a larger portion of female than male providers, but the patient population consisted of equal numbers of

women and men (Howe et al., 2010). Despite the fact 70% of the patient population was obese, the word ‘obese’ or ‘obesity’ was documented in only 19% of the patients with obesity admitted during the study and a plan to treat obesity was found in only 7% of the charts. Documentation of obesity (e.g., initiation of a low calorie diet, counselling about weight loss or nutrition consult) was slightly higher and present in 20% of the charts. Younger patients were more likely to have obesity documented than older patients (85% vs. 55%). Thirty hospitalist providers were also surveyed to collect information about attitudes and self-reported behaviours. This study showed that providers were not regularly documenting obesity or initiating plans to address this public health issue; demonstrating that suboptimal healthcare was being provided to those who are overweight (Howe et al.). The reasons reported for not documenting obesity was lack of time and failure to see it as an acute issue, despite data to suggest the increased risk of a number of diseases (Howe et al.). It should be noted that this was a pilot study, involving only one medical centre and a small number of providers. Howe et al.’s (2010) study demonstrated that hospitalists (physicians who provide inpatient hospital care) are failing to identify and initiate intervention for the increasingly problematic public health issue of obesity.

A similar study involving the management of obesity in primary care was conducted by Moore et al. (2003). They used a clustered randomized experimental (single blinded) design to evaluate a training program intended to improve the management of obesity. The study was conducted in England with 843 patients sampled from a total of 44 practices. Of the 22 intervention practices, general practitioners and nurses attended three 90 minute education sessions that promoted a model approach to

obesity. The other 22 practices comprised the control group and the health care providers were asked to provide usual care. Randomization was based on patient and practice level characteristics and the patients were not aware of the intervention status of their practice. The model approach to obesity management involved seeing patients until they had lost 10 percent of their original body weight. The primary outcome measure was a difference in mean weight of patients between intervention and control practice groups at 12 months. Differences were also measured at 6 and 18 months, along with assessment of knowledge of obesity management. Results showed that the intervention group were heavier (-1.9 to 3.9 kg) than the controls; that is, the brief training program on obesity management delivered to general practitioners did not affect weight change (difference in patient's weight after the training) of the participants. Moore et al. 2003) suggested a more in-depth training program or other method is necessary for successful management of patients with obesity and the program should exist along the continuum of care.

According to Hamdy (2010), hospitalists often take the position that obesity is not the presenting problem and thus should be addressed by the patient's general practitioner, despite the fact many of the health problems may be secondary to the obesity. Because obesity is not solved easily (e.g., with a prescription), the counselling is postponed from visit to visit and seldom gets addressed. Hospitalists need to be educated on how to intervene with patients with obesity and to enable them to address obesity, through collaboration with dieticians, family doctors and their social networks (Hamdy, 2010).

2.4.2 Equipment and Resources

Management of the patient with obesity does not only involve counselling on diet and exercise strategies and managing the associated diseases, it also involves the physical environment; the field of bariatrics. According to Wilson (2006) facilities must be prepared for the bariatric patient as increasing numbers of patients with obesity are entering the health care system with weight related complications. Preparation includes having the equipment, accessible space and trained individuals (Wilson, 2006), along with clear, early documentation of obesity (Howe et al, 2010). Having appropriate equipment and space minimizes the risk of injured workers and maximizes the provision of quality health care. The physical space, equipment, commitment of all members of the multidisciplinary team and appropriate policies and procedures are necessary, as environmental barriers should not impede upon patient needs (Wilson, 2006). These measures aid in establishment of a more sensitive environment. Clearly, discrimination against the patient with obesity exists, however it is more profound when the tools and resources are not available as there is a tendency to avoid care (Camden et al., 2008). Fear on the part of the patient and the caregiver (i.e., health professionals) creates a barrier to empathetic care (Camden et al., 2008). Health care workers, in particular nurses, are involved with the patient with obesity during some of their most vulnerable and private moments, so education and resources are crucial to management and care of this population (Camden et al., 2008).

Resources are also necessary in the emergency department (ER) - the point of entry of patients into hospital care. Anecdotal evidence suggests that equipment in ERs are inadequate in size and capacity, which impacts quality of care (Singh, Arthur,

Worster, Iacobellis & Sharma, 2007). Also, the issue is becoming increasingly problematic as more and more patients with obesity are visiting the ER (Singh et al., 2007). Singh et al. (2007) conducted a quantitative study in Canada involving administration of questionnaires to patients and nurses assessing the adequacy and perceived adequacy of equipment, respectively. The aims of the study were to assess patients' and nurses' perceptions of equipment adequacy for patients with obesity presenting to the ER and to assess nurses' knowledge of weight limits of equipment in the ER. For the purpose of this study, equipment was defined as items such as beds, gowns, toilets, blood pressure cuffs. A prospective, descriptive, questionnaire study design was used. To maintain homogeneity in the presenting issue, patients with cardiac ischemia were recruited. A cross-section of BMI categories was included to detect differing perceptions across weight categories. Nurses treating the patients in the ER were recruited to complete the nurse questionnaire component of the study. Results from the 134 patient questionnaires, showed an inverse correlation between equipment adequacy and both BMI and waist circumference. Similar results were found in 47 nurse questionnaires, with equipment adequacy scores inversely correlated with BMI and waist circumference of the patient. Although results of the study are limited by use of self-report measures for height and weight and use of a tertiary care academic centre (limits ability to generalize), Singh et al. (2007) concluded that both patients and nurses perceive ER equipment as inadequate; subsequently risk of accidents and injuries increases and quality of care decreases.

Research suggests that equipment, care providers and documentation guidelines are lacking in hospitals to meet the needs of persons with obesity. Equipment does not

meet appropriate weight capacity standards and health professionals are unaware of what the equipment can sustain, posing safety issues for both the patient and the care provider. In conjunction with this is lack of documentation to alert caregivers of specific patient needs. Subsequently the bias, the prejudice and lack of quality care for the patient with obesity persists in the hospital environment.

2.5 Health Professionals and Obesity

2.5.1 Physicians

As previously discussed, addressing the escalating rates of obesity is an area of priority for public health (Campbell & Crawford, 2000). It is recognized that there is a need for overweight and obesity prevention strategies (Campbell & Crawford, 2000). Methods to reverse the trend of consuming energy dense foods include regulation of labeling, lowering costs of grains and low fat milk and education. However, with a significant proportion of the population already being overweight, management of obesity is also a priority. Prevention and management have implications for health professionals (Campbell & Crawford, 2000). Obesity increases the risk for chronic illness, so treatment of these diseases will have a significant impact on future healthcare costs (e.g., Alexander et al., 2007). The problem is that weight management is not adequately addressed in primary care (Ferrante, Piasecki, Ohman-Strickland & Crabtree, 2009). Negative attitudes are prevalent, particularly in young physicians and those with low patient volume (Ferrante et al., 2009). Education on weight loss diets however would increase physicians comfort with discussing weight loss and would increase belief in

patient success (Ferrante et al., 2009). Respect for all patients, a core component of professionalism, is needed (Huizinga et al., 2009).

The United States Preventative Service Task Force (USPSTF) recommends that physicians screen all patients and offer assistance for obesity; however weight loss is addressed in less than 20% of visits (Alexander et al., 2007). To gain insight into the beliefs, outcomes and strategies to address this condition Alexander et al. (2007) conducted a qualitative study involving focus groups. Eleven family physicians and six internists participated. Questions included: 1) what are your views and opinions about obesity?; 2) how do you discuss obesity with your patients?; and 3) what are your views on the USPSTF's recommendations? The themes that emerged from the data included responsibility (e.g., *"whose is it, if only one person wants it, it is nearly impossible"*); barriers (i.e. low outcome expectancies, lack of training, vague guidelines); target populations (i.e. who should have their weight addressed with race, gender and weight being factors); how is the topic introduced (i.e. by patient or by physician); and finally how is the problem resolved (i.e. refer to a dietician, provide the basics or talk diet and exercise). These themes or barriers indicated that many physicians do not discuss weight loss, with the major influencing factors being lack of training, limited resources and poor patient outcomes (Alexander et al., 2007). This is consistent with Huang et al. (2004) who found physicians provided insufficient guidance on weight management because of inadequate counselling skills and confidence in managing the obese patient.

Barriers to weight loss counselling were investigated by Huang et al. (2004) in a study involving focus groups of primary care physicians. Themes were identified from four groups (six members in each); six faculty and 18 residents participated. Themes

were rank ordered based on frequency of discussion. In addition to physician involvement in this study, 210 patients were interviewed upon discharge from the hospital. The barriers identified by the physicians in this group included pessimism about patient's desire and ability to lose weight, pessimism about effectiveness of weight loss, lack of resources, lack of time, lack of counselling skills and underuse of other health professionals such as dieticians (Huang et al., 2004). However patients who did receive advice demonstrated a better understanding of the associated health issues and were more motivated to engage in weight loss activities. This study showed that physicians have a strong influence on patients from both a knowledge and behavioural perspective when they provide weight loss counselling (Huang et al., 2004).

There is increasing literature on patient-physician communication as research indicates its effectiveness is linked to increased adherence to treatment, understanding of medical advice and health outcomes. A study comparing perceptions between physicians and patients and the subsequent implications for practice was conducted by Pulvers et al. (2008) in the United States. The basis of this study was that differences in perceptions and expectations pose barriers to effective communication about weight loss and subsequently hinder patient motivation. A paired survey method was used involving medical students' administering a questionnaire to patients with BMI ≥ 30 followed by administering a questionnaire to the patient's physician. The patient's questionnaire involved identification of a body image that they perceived to be most representative of their own figure and classification of their weight from very underweight to very obese (Pulvers et al., 2008). Physicians used the same instrument to select the figure that best resembled the appearance of the patient. Level of agreement between physician and

patient figure ratings and weight classifications was statistically evaluated. Male patients generally selected smaller figures for themselves than did their physicians, whereas female patients and physicians were more comparable in their ratings. Similarly, with weight classifications there was a larger spread in BMI between male patients and their physicians' perceptions compared to female patients and their physicians' perceptions. Although body image is multidimensional and includes more than classification of weight, Pulvers et al. (2008) believed that differences in perceptions between patient and physician impacted communication, particularly with males. Research has shown that people will interact with people and in environments where their self-concept is verified instead of challenged (Pulvers et al., 2008). Settings and situations that are inconsistent with one's self concept will be avoided. Avoiding or delaying medical treatment may be detrimental to overall well-being of patients. Devaluing physicians' recommendations may also lead to future increased medical costs and possibly ineffective treatments. Clinically, the focus of treatment (or weight management) should be on behaviours related to diet and exercise, not just weight loss (Pulvers et al., 2008). Also, how this message is portrayed by physicians and received by patients' is of extreme importance (Pulvers et al., 2008). This study and the research previously discussed consistently demonstrates that training in weight loss, training in communication (with patients) and improved guidelines are necessary to manage obesity (Alexander et al., 2007).

When approaching the topic of weight with patients the style and language used is important (Al-Ghawi & Uuay, 2009). Al-Ghawi and Uuay (2009) conducted a cross-sectional study in Bahrain using a self-administered questionnaire to examine the role of physicians in obesity control and to evaluate their knowledge and attitudes toward

prevention and management of obesity in primary care. A single stage cluster sample was used due to limited time and resources. Ten of 22 health centers in the area were selected at random with all physicians included. Ninety-seven participants (90% response rate; 29 males and 68 females) completed the questionnaire. The questionnaire included sections on weight problem identification and weight loss strategies. Likert-scales were used for which participants had to indicate their level of agreement with a number of statements. Results were presented mainly as frequencies. The majority of physicians (92%) agreed that obesity was a problem, requiring urgent action, with two thirds stating that only a few patients who are overweight have the ability to lose and maintain the weight loss. Only 30% of the physicians screened their patients regularly for weight problems. Referral to dieticians occurred regularly by 41% of the physicians and nearly all participants included diet and exercise as lifestyle advice. Physicians were more confident treating individuals who were overweight than patients with obesity, but with training, confidence in treating individuals of all weight ranges, including those with obesity increased. Barriers to management included short consultation times, absence of guidelines and inadequate training in counselling patients with obesity. Although there were limitations such as the short questionnaire (i.e. limiting the scope of information gathered) and use of weight measurement as the identifier for weight problems; there was a significant strength in the response rate. This study identified that physicians were aware of the magnitude of obesity and how their attitudes and practices played an important role in obesity management. There remains a gap however between attitudes and practices and efforts are not always successful. Further study, training, collaboration

of professionals and development of guidelines is necessary to combat the epidemic (Al-Ghawi & Uuay, 2009).

Hebl and Xu (2001) conducted a similar study in the US to examine the reactions of physicians based on the size of a patient. One hundred and twenty-two physicians who were affiliated with one of three large hospitals located in the Texas Medical Center of Houston participated in the study. To examine responses a two (gender) x three (weight) factor design was used. Following the evaluation of a medical chart, the physicians completed two forms – medical procedures form and patient follow-up questionnaire. The medical procedures form consisted of a list of medical procedures and the physicians were asked to indicate all the tests, procedures and referrals they planned to complete in caring for the patient. The patient follow-up questionnaire asked physicians how much time they would spend with the patient and assessed 13 affective and behavioural reactions the physician had toward the patient: 1) personal desire to help the patient; 2) seriousness of the medical problem; and 3) how self-disciplined they perceived the patient to be. The charts depicted patients as average weight, overweight or obese, who presented with a migraine headache. Researchers chose this medical problem as it is generic and treatment should not be related to a patient's anthropometrics (Hebl & Xu, 2001). Analysis of the medical procedures form indicated that recommended procedures were strongly related to the weight of the patient. Results indicated that the most medical procedures (i.e. tests and referrals) were recommended for patients with obesity, the second most for patients who were overweight and the least for patients of average weight. The type of procedures recommended also differed in terms of patient weight. For example, the stigma of obesity was evident as the physicians were more likely to

recommend psychological counselling patients with obesity, suggesting the physicians' perceived the patients to be unhappy. Results of the patient follow-up questionnaire showed similar results - the heavier the patients were, the more negative the (physicians) attitude (toward the patient) and use of distancing behaviours (i.e. seeing this patient would be a waste of my time) (Hebl & Xu, 2001). Although it is questionable whether the results of the study would translate into actual practice, Hebl and Xu (2001) demonstrated that the quality of care provided by a physician was largely influenced by the weight of the patient.

Obesity is often dismissed as a personal failing so it is not treated on par with non-stigmatized medical conditions (Huizinga, Copper, Bleich, Clark & Beach, 2009). In a survey of physicians, Huizinga et al. (2009) reported that obesity was identified as a characteristic that elicited negative feelings and reported ambivalence toward treatment of obesity. Huizinga et al. (2009) hypothesized that physician respect for the patient was inversely associated with BMI. Data to test this hypothesis was collected from the baseline visit of a larger study entitled the Patient-Physician Partnership Study, a randomized control trial focused on improving patient-physician communication. The independent variable was patient BMI, with physician respect for the patient being the dependent variable. Questionnaires about the visit, their attitudes and perceptions (of one another) were completed by both patients and physicians. Level of respect was based on rank using a five-point Likert scale, with two categories created: high respect (four to five) and low respect (one to three). Information on race and gender was also collected. Analysis showed that physicians had low respect for 39% of the participants. Physicians had less respect for patients with higher BMI's and for those that were younger. The

prevalence ratio of low respect by BMI was evident per 10 kg/m² increase in BMI. In general, this study showed that physicians had lower respect for those patients with a higher BMI, regardless of age, race or gender. The problem is that the quantity of information provided is often related to amount of respect, subsequently, patients may not receive adequate treatment based on their anthropometrics. Patients demand require respectful relationship, otherwise they may avoid healthcare (Huizinga et al., 2009).

2.5.2 Nurses

Nurses also play an important role in lifestyle intervention. In the United Kingdom, Brown, Stride, Psarou, Brewins & Thompson (2007) used a correlational survey design, to investigate the practices, beliefs and attitudes of primary care nurses in the management of obesity. For this study, the sample included district nursing team staff, health visitors and practice nurses. A questionnaire was completed by 398 staff (response rate of 72.3%), 96% of whom were female. The participants were asked about their clinical practice activities in terms of the number of individuals assessed and supported in weight management in the previous four weeks. Beliefs, attitudes and views related to concepts of personal effectiveness, consequences and causes of obesity, management practice and organizational support were also measured. A five-point Likert scale was used to measure level of agreement with statements such as: 1) a patient's weight is really none of my business; 2) obesity puts an individual at high risk of cardiovascular disease; and 3) I think obesity is an important area for developing services. A majority of the respondents either strongly agreed or disagreed (88%) that the importance of obesity as a risk to health is overstated. Over half of nurses (58.5%) also

agreed that most problems for patients with obesity were due to the obesity. There was also the tendency to believe obesity was due to lack of will power around food (34.7%) and only 8.2% agreed that patients were motivated to change. Respondents also did not feel there was strong organizational support. These and other statements were categorized into the concepts listed above (personal effectiveness, consequences and causes of obesity, management practice and organizational support) and mean scores were examined. There was a slight positive rating of personal effectiveness; meaning not feeling awkward or embarrassed about discussing obesity with clients. The importance of obesity was rated highly indicating that obesity was deemed an important issue for health and health service development. There was lack of agreement however on the relevancy of external causes, defined as factors outside personal control or responsibility of individuals, as the cause of obesity. Finally, there were fewer negative views about obesity and levels of organizational support were perceived to be low (Brown et al., 2007). Correlations showed that a higher sense of personal effectiveness was related to organizational support and external causes were negatively related to importance of obesity. Training was also positively correlated with personal effectiveness and organizational support. Although the questionnaire had good content validity, some scales had low internal reliability. Also a regional, not a national sample was used so results are to be reviewed with caution in terms of generalizability. Overall, findings showed that nurses think that obesity is an important health issue and that they had a role to support patients with weight management. However, very few nurses had the proper training and guidance and they did not perceive the organizational support to be present. Considerable development and training is necessary for primary care and practice nurses

to ensure effective programs are put in place and that obesity remains a priority for international public health (Brown et al., 2007).

A similar study was conducted by Poon and Tarrant (2009) using a cross sectional design. As in the study by Brown et al. (2007), the purpose of this study was to investigate nurses' attitudes towards and the management of patients with obesity. A self-administered questionnaire was completed by 352 undergraduate nurses and 198 registered nurses in Hong Kong, where lower thresholds are used to define overweight and obese (BMI \leq 23 and 25 subsequently). The questionnaire consisted of the Fat Phobia Scale (FPS), the Attitudes toward Obese Patients (ATOP) scale and a demographic profile. As in the study by Brown et al. (2007), the majority of respondents were female (86.6%). Scores on both scales ranged from one to five. A mean score of 3.53 (FPS) indicated average levels of fat phobia and a mean of 2.64 (ATOP) indicated that attitudes were largely neutral. However, the majority perceived that the obese liked food, were more likely to overeat, were shapeless, slow and unattractive. Comparisons of the scales also revealed that registered nurses' attitudes were typically more negative than the student nurses', which suggested that experience had a negative impact on the provision of care. Age may have also been a factor, as the registered nurses were significantly older than student nurses. This study is consistent with others in that it demonstrates negativity toward the care of the obese. Nurses played a key role in counselling and assisting patients to lose weight and in caring for patients who were obese or who have obesity related health problems; however, to be effective in providing care, nurses must be non-judgmental (Poon & Tarrant, 2009). Overall, attitudes of the Asian nurses in this study were substantially more positive than those of Canadian and

American nurses in comparable studies that used the ATOP items (Bagley et al., 1989; Maroney & Golub, 1992, cited in Poon & Tarrant, 2009). Results may be positively slightly skewed as 63.9% of the respondents were students, whose preparation by faculty may have had more positive impact on attitudes. Also, it was concluded that obesity education should be a component of undergraduate programs for student nurses and of continuing education programs for registered nurses (Poon & Tarrant, 2009).

A qualitative study conducted by Jeffrey and Kitto (2006) on an Australian Bariatric ward used an exploratory design with thematic analysis to identify recurring themes in the care of patients with obesity. The aim was to explore perceptions and experiences of caring for patients with obesity in the context of an acute general surgical ward, which specializes in bariatric surgery. A purposeful sample of female registered nurses with extensive experience in a bariatric ward was used. The minimum time spent on the ward was five years and the maximum was 18 years. Data was collected to saturation, which involved ten semi-structured interviews. From analysis and coding three major themes emerged: competing perceptions of obesity, ambivalence towards weight loss surgery and obese patient responsibility. *“Tasks have nothing to do with size,” “it is not for us to make judgments,” “it affects all aspects of their lives,” “I don’t believe there is a surgical cure,”* were some of the comments related to perceptions (Jefferey & Kitto, 2006). Conflicts in the approach to care were evident in comments on weight loss surgery (*“it is a quick fix”*) but others recognized that *“losing weight is hard and maybe they do need medical intervention.”* The challenge is that holistic care is consumed by the biomedical model; that is, nursing work includes emotional, psychosocial and spiritual aspects of care as well as the physical component of care

(Jefferey & Kitto, 2006). Bariatric surgery however, only deals with the biophysical component of ‘intake and output’; it does not deal with why the patient overeats or the social factors associated with obesity, such as isolation or unemployment (Jefferey & Kitto, 2006). With respect to patient responsibility it was argued that individuals shape their lives through their own choices, “*just wonder why the hell they could not keep the weight off*” and “*are the patients actually aware of the risks of surgery.*” Although judgments do fluctuate, this study showed that medical dominance is the central factor shaping nurses opinions and perceptions of their work, particularly on a surgical ward. The care became dominated by treating the surgical patient and not addressing the responsibility of and concerns associated with being obese. There are significant theoretical and practical components to nursing, in addition to the medical discourse. New ways for nurses to assert themselves and new models for care of the bariatric patient are needed in this growing area of health care (Jefferey & Kitto, 2006).

2.5.3 Allied Health Professionals

Physical therapists are health care professionals, who promote health, wellness and fitness. They also manage conditions related to movement and function (Sack et al., 2009). Because of their skills and knowledge of aerobic capacity, muscle strength and joint capacity, physical therapists also play an important role in the management of obesity. Attitudes and knowledge are two variables that can influence practice approaches (Sack et al., 2009). Therefore, Sack et al. (2009) conducted a prospective paper mail survey of a random sample of the American Physical Therapy Association. The purpose of the survey was to study physical therapists attitudes, knowledge and

practice approaches regarding the obese and the relationships between attitudes and knowledge. A pilot survey was conducted, followed by modifications to further validate the study tool which consisted of 31 items. Multiple choice, fill-in, Likert-type scale and true-or-false formats were used to assess the domains of causes of obesity (e.g., restaurant eating), attitudes toward obesity (e.g., most people who are obese will not lose a significant amount of weight), attributes of people who are obese, efficiency of treatments (e.g., exercise) and weight loss outcomes. There were 345 surveys returned with 87.2% ($n = 301$) reporting they provided care to patients with obesity. Among the conditions that caused obesity, physical inactivity and overeating were rated as very important. With respect to attitudes regarding statements of obesity, there was strong agreement (73.9%) with the statement “obesity is a chronic disease associated with serious medical conditions” and 85.4% felt they should be role models by maintaining normal weight. There was also about 50% that felt persons with obesity were not strongly aware of the long term risks associated with their condition. With regard to treatment for obesity 83.2% of respondents believed diet and exercise were the most effective. In describing patient’s with obesity, at least half of the physical therapists viewed them as awkward and unattractive. Despite the perceived importance of the physical therapists role in the treatment and management of obesity, 30% said textbooks were not effective sources of information for understanding obesity and they indicated that previous experience was the key to effective treatment (Sack et al., 2009). Analysis of correlational data showed a strong belief in psychological problems causing obesity and subsequent frequent referral to psychiatrist. There was a significant correlation between knowledge scores and attitude toward obesity. It was also found that even though the therapists’ believed in the

combination of nutrition counselling and exercise; there were few referrals to dietitians. Overall, therapists had a neutral attitude about obesity and results indicated that physical therapists believed that environmental and behavioural factors were more important causes of obesity compared to genetic or metabolic factors. Also, the ranking of physical inactivity as the main cause of obesity was consistent with the respondents' training as experts in physical activity. This study did have a strong response rate, but only 45% of respondents could identify a healthy hip to waist ratio, which may skew results. Also, the survey questionnaire was developed from a non-validated tool. Although physical therapists attitudes were considered impartial based on this study, further education on the importance of the therapist's role in treating the patient with obesity is needed and additional studies with stronger research designs are recommended to validate the impartiality and effectiveness of treatment (Sack et al., 2009).

Another group of health professionals who play a significant role in the management of the obese are dietitians. Weight management forms a substantial component of dietitian's workload (Campbell & Crawford, 2000); therefore proper training and positive attitudes are important to successful practice. In Australia, Campbell and Crawford (2000) conducted a study assessing attitudes of dietitians among a random sample of dietitians from members of the Dietitians Association of Australia (90% of dietitians in Australia were a members of this organization). A pilot tested survey was mailed to 602 dietitians. The questionnaire included measures of 1) profile (e.g., sociodemographics, work status); 2) views of obesity (e.g., major cause of morbidity and mortality, weight cycling is a risk to future health); 3) education and training (e.g., how adequate was basic training in helping them to assist people with

weight management); 4) definitions of success (e.g., improved body image, adoption of improved food and weight loss habits); 5) approaches/strategies (e.g., how frequently were weight management activities performed); 6) best practice in weight management (e.g., matching clients to management approach, promoting regular physical activity); and 7) general problems and comments related to treating the client with obesity. Qualitative and quantitative data was collected, with open ended questions coded and relationships examined using ANOVA. There was a 66% response rate to the survey with 400 surveys returned (Campbell & Crawford, 2000). There was strong agreement that obesity was related to increased risk of morbidity and mortality, not all individuals with a BMI > 25 needed to lose weight and long term management was essential. As a group, the dieticians ($n = 60\%$) felt they were the best trained professional to offer advice and support to obese patients. However only 48% reported feeling professionally prepared to treat clients who were overweight. Experience was an important factor in confidence to treat and as well as the approach used in management. Similar to the study by Howe et al. (2010) the majority (90%) stated that weight management was of low priority in the hospital. As well the majority stated that time constraints and poor facilities limit the services that could be offered. Advice related mainly to calorie reduction but many also indicated that emotional and social issues must be addressed simultaneously. Successful weight loss was believed to be limited, but measures of success varied from improved food and exercise habits, to weight loss, to achievement of normal weight. Common frustrations included lack of client commitment and lack of opportunity for follow-up, secondary to limited resources. Based on the above, it is evident that although dieticians recognize the importance of their role in obesity management, lack of best practice

guidelines, attitudes of lack of client commitment and limited resources (that would allow for long term follow-up) impede upon dieticians very important role (Campbell & Crawford, 2000).

Review of the attitudes of physicians, nurses and allied health professionals indicate that health professionals are all aware of the rise in prevalence of obesity and its potential for related negative health outcomes. The presence of negative attitudes and the use of the medical versus a holistic model are evident. The risk of increased morbidity and mortality are documented, however, the training and resources are lacking. Obesity has not been given the priority it demands (Campbell & Crawford, 2000). The need for health authorities to acknowledge the issue and advocate for services is highlighted.

2.6 Knowledge and Research Gaps

Literature in this area primarily focuses on weight stigma amongst the adult population. The area of obesity and bariatrics however is a relatively new and emerging field. As with any new area of research there are gaps in content and design or methodology. The following aims to synthesize these gaps and identify future areas of study in the emerging field of bariatrics and healthcare for people with obesity in general, in particular in the area of attitudes and perceptions of persons with obesity and their providers in the healthcare system.

2.6.1 Knowledge in Prevention, Understanding and Treatment

As an emerging area of research, limitations in understanding obesity, its cause and its treatment exist. There are areas that are understudied, topics that are just surfacing for study and areas that are not well understood. There is a failure to realize that obesity

is a chronic illness (Wagner et al., 2001), that gender discrepancies exist and physician expectations are unrealistic (Dutton et al., 2010), to name only a few gaps in this area of study.

Obesity is not seen as a chronic illness. Wagner et al. (2001) focused on the development of a chronic care model and in doing so discussed a variety of gaps that exist in the current system of care. During hospitalization the acute problem not the underlying cause or chronic condition was treated (Wagner et al., 2001). A continuous healing relationship with follow-up and planning and coordination of multiple caregivers is not established. A chronic care model needs to be developed for the proper management of obesity (Wagner et al., 2001). “Fitting in” to the current acute care model is not the answer to addressing the prevention and treatment of obesity (Wagner et al., 2001). Further research in acute, clinic, outpatient and primary care is also recommended. Research in these areas is needed to address the relationship between bias and accommodation; i.e. the failure to provide seating, beds, instruments and diagnostic equipment that accommodate larger people so their health issues can be properly assessed (Camden et al., 2008). This concept corresponds with Hilbert, Reif and Braehler’s (2008) work on the determinants of stigmatizing attitudes towards obesity. For example, there is evidence to support that men show greater stigmatization of obesity than women, but there is lack of evidence on socioeconomic correlates of obesity. Clarification of the psychological and sociodemographic determinants of stigmatizing attitudes toward obesity is needed (Hilbert et al., 2008). Many believe that obesity is a behavioural condition resulting from lack of willpower, so more publications on etiology of obesity and the clinical relevance of the disease are needed. In conjunction with this, it has been

suggested that obesity needs to be classified as an illness. If classified as an illness obesity may be more accepted and subsequently less stigmatized (Hilbert et al., 2008; Wagner et al., 2001). Knowledge of all conditions that result in stigmatizing attitudes is warranted to identify starting points for stigma reduction (Hilbert et al., 2008).

Obesity is insufficiently understood and ways to ameliorate stigma as well as the etiology of weight bias. This was studied by Puhl et al. (2005) who found that persons with obesity were blamed for being overweight despite evidence that body weight is determined by a complex interaction of biological and environmental factors. Also, there is a lack of evidence on the prevalence rates of measurable traits amongst people with obesity and literature states there is an overestimation of non-compliance with physician's recommendations, but no data to support the existence of this relationship. There is also a limited understanding of the psychological and social targets of intervention that are needed to change the hostile societal environment that people with obesity face. Identifying measurable traits and educating about uncontrollable causes of obesity may help reduce negative attitudes. Advancement in this field is necessary as limited experimental work has compared stigma reduction methods on attitudes toward obese people and the research that has been conducted shows mixed findings (Puhl et al., 2005).

Weight bias can also be associated with gender. Women tend to endorse greater weight loss goals than men and patients are more likely to attempt weight loss if it is recommended by their physician (Dutton, Perri, Stine, Goble & Vessem, 2010). Regardless of gender, weight loss goals are typically beyond what may be achieved through lifestyle modifications and are more stringent for women (Dutton et al., 2010). It is unclear, however if the greater weight loss expectation for females is due to women's

greater expectations or if they are due to physician biases of gender-specific ideal body sizes. There is also a question of whether female physicians are more realistic in their expectations than male physicians. More research is needed to better understand gender discrepancy in physician expectations for obese patients (Dutton et al., 2010). In conjunction with gender discrepancy is the need to find tools to enhance the patient-physician visit particularly for males (regarding weight issues) as they are less likely to seek medical care (Pulvers et al., 2008).

In addition to seeking health care, other health beliefs and behaviours of obese individuals vary according to the severity of obesity (Lewis et al., 2010). Understanding the socio-cultural and individual factors associated with these beliefs and behaviours is important for developing appropriate interventions and for developing population based messages to encourage change. Knowledge regarding the impact that the public focus on obesity has on people who are obese is needed; for example, are health and policy responses stigmatizing and disempowering people with obesity to address their health risks (Lewis et al., 2010)?

Dietitians are health-care providers who are considered to be important providers of weight management advice (Campbell & Crawford, 2000). However, there is limited data on dietitians' attitudes and practices with the obese population. It is shown that length of treatment and follow-up is correlated with weight loss but low priority is typically given to the treatment of individuals with obesity. There is a need to explore the knowledge base, time constraints, prioritization policies and attitudes of dietitians to minimize weaknesses in practice within this profession (Campbell & Crawford, 2000).

It is evident in the literature reviewed and discussed that the halo effect is a major component of the research on persons who are overweight and obese. That is, the perception of one trait is influenced by the perception of another. Due to a person's size, stereotypes of laziness and lack of concern for self are prominent. This weakens will power and personality and triggers thoughts of lack of self-control, reducing the ability to engage in weight loss behaviours. Beliefs of lack of motivation and personal responsibility need to be challenged to improve empathy and enable the development of obesity management policies (Brown et al., 2007).

The above indicates that there are gaps in research regarding the attitudes and perceptions pertaining to the provision of healthcare for people who obese. There is also limited research on the perceptions of people who are obese themselves in terms of their views of healthcare offered and received. Given that obesity is a growing in prevalence and the current stigma mimics that of racial discrimination (Carels & Musher-Eizenman, 2010), continued research to eliminate these gaps is warranted. Research on physician attitudes and treatment approaches, dieticians' effectiveness in weight management, therapists' goals, clinical relevance of obesity and gender differences related to body image, are just some of the areas where further study is recommended.

2.6.2 Limitations of Previous Research Design and Methodology

The research reviewed on attitudes towards individuals with obesity and the hospitalization and health care of the obese has several limitations in terms of methodology. The quantitative research on obesity shows some inconsistent results with the use non-validated survey scales and instrumentation, poor sampling techniques, and

study response rate. There is also a lack of mixed methods approaches to this area of study.

2.6.2.1 Measurement and Instrumentation

It is important to utilize valid and reliable measures in research to add credibility and acceptability of your work in the scientific community. Hilbert et al. (2008) in their study on stigmatizing attitudes toward obesity used a scale that was validated but was believed to yield higher levels of causal attributions than associations because of its focus on willpower and blame. The scale used by Brown et al. (2007) was also questioned as it demonstrated good content validity but limited internal validity. Likewise, Sack et al. (2009) in their study of attitudes of physical therapists and approach to people who are obese used a survey questionnaire that was adapted from a non-validated tool. The tool was used to study physicians and was descriptive in origin. Similarly, Puhl et al. (2005) used self-report measures as their measurement tool, as did Sack et al. (2009) to get height and weight measurements for the calculation of BMI. There is a risk of inaccuracy with self-reporting, as heights and weights are likely to be over and underestimated respectively, thereby BMI calculations will also be inaccurate, providing false research results. Experiments using self-report tools are questioned in their ability to demonstrate genuine change and their ability to translate into concrete behavioural changes. An additional limitation of the Sack et al. (2009) study was the construct validity of the attitude questionnaire. Carels and Musher-Eizenman (2010) also used MyVirtualModel software for the male and female figures rather than real photographs limiting the ecological validity of the study. The range of BMI's used was also restricted, figures

spanning a greater range and a better distinction within weight categories would increase validity of results (Carels & Musher-Eizenman, 2010).

2.6.2.2 Sampling Techniques

Sampling is critical to a research study as the strength of the sample will impact the results and outcome. Strong procedures and sampling strengthen research, but may not always be feasible. Recruitment is often a challenge so convenience samples are used such as the undergraduate psychology class used in Carels and Musher-Eizenman's (2010) study. This study offered credit for participating; therefore intentions may not have been altruistic. The problem is underrepresentation of age and ethnicity yield an inability to generalize results. Self-selecting participants from a group of weight loss participants as in Carels and Musher-Eizenman's (2010) study on implicit and explicit bias may not generalize to other weight loss methods or to those who are maintaining prior weight loss. From this study it remained unclear if there was an association between weight based stigmatizing events and psychosocial maladjustment as the sample consisted of only 54 participants, the majority of whom were female (82%). Poon and Tarrant (2008) also utilized convenience sampling to examine attitudes of Asian undergraduate nursing students towards patients with obesity. The majority of this sample was also female (86.6%); so again generalizability is to be applied with caution. Another study by Brown et al. (2007) did not use a nationally representative sample and mostly females (96%) responded, yet another example of gender response bias within the nursing profession. Hilbert et al. (2008) also did not include ethnicity and lower socioeconomic groups were underrepresented, limiting the generalizability of the results. Similarly, Puhl

et al.'s (2005) consisted of college students and the population studied was not ethnically diverse. Dutton et al. (2010) conducted their study in locations in Florida; beliefs and norms are typically socially constructed, so studying locations in one particular geographic region may limit the geographical generalizability of the study. Similar to Dutton et al. (2010), Pulvers et al. (2008) used a convenience sample of a homogeneous ethnic population in a defined geographic region to compare body perceptions between patients and physicians. In order to understand societal attitudes towards people who are obese it is important that studies are conducted among a variety of different groups and populations as well as to generalized national populations.

2.6.2.3 Study Response Rate

Response rate is a factor that can limit the quality of the results of a study. A low response rate minimizes the reliability and validity of study results. For example, in a study by Dutton et al. (2010) the aim was to compare physicians' weight loss goals for male and female patients with obesity. Only 25% of physicians contacted completed the study, of which 75% were male (Dutton et al., 2010), yielding non-respondent bias. Replication of the study is warranted to obtain equal number of male and female physician participants. Failure to calculate response rate is an important consideration as well, as the results may be due to response bias and not the variable being studied (Pulvers et al., 2008).

2.6.2.4 Lack of Mixed Methods and Qualitative Approach

Quantitative methods were use in the majority of the studies reviewed on stigma and discrimination towards people who are obese and hospitalization and healthcare for

people who are obese. Survey methodology was most commonly used to collect data in these studies. Results from survey data may be limited by the question asked (i.e., design bias), whereas qualitative and observational studies are broader and more open-ended (Dutton et al., 2010). Qualitative research would add a new dimension to the understanding of the complex factors associated with obesity (Lewis et al., 2010). Inclusion of more qualitative methodology (e.g., interviews, narratives) would provide a descriptive and more personal component to the understanding of the hospitalization experience and health care received among this population. Little is known from the perspective of people with obesity as research is lacking on the experience of individuals who are obese.

This chapter aimed to review the literature related to attitudes, perceptions and experiences of persons with obesity and health care professionals within the health care system and to synthesize potential gaps in this area of research, in terms of both content and design. Weight bias translates into inequities in all aspects of life. Therefore it is necessary to increase knowledge in the management, care and understanding of the physical, emotional, psychological, genetic, behavioural and physiological components of obesity. Existing research serves as the baseline upon which to develop more encompassing and methodological sound obesity studies.

CHAPTER 3: HOSPITAL EXPERIENCES OF PEOPLE WITH OBESITY

3.1 Introduction

3.1.1 Obesity and Public Health Impact

Because obesity is increasing in both developed and developing countries (e.g., Cooper, Page, Fox & Mission, 2000) it is being considered a worldwide issue and public health challenge (Peterson, Schnohr, & Sorenson, 2004; Poon & Tarrant, 2009). Obesity is defined by the World Health Organization (WHO; 2014) for males and females over 20 years of age, as having a body mass index (BMI) over 30. BMI is calculated as weight in kilograms (kg) divided by height in meters squared (m^2) (Cooper et al., 2000; Spence-Jones, 2003). Obesity is divided into three classes: 1) Class I – BMI of 30.0-34.9 kg/m^2 ; 2) Class II – BMI of 35.0-39.9 kg/m^2 ; and 3) Class III – 40 kg/m^2 (WHO, 2004). Class III obesity is also described as morbid obesity. According to Shields, Carroll and Ogden (2011) and the Canadian Health Measures Survey (CHMS) the prevalence of obesity in Canada was 24.1% and was even higher in the United States at 34.4% in 2007-2009. Within Canada, the province of Newfoundland and Labrador has one of the highest rates of obesity: between 64 and 71 % of the population has obesity (Statistics Canada, 2005). The challenge of preventing and managing obesity relates to its personal, social and health effects and the fact that the etiology of obesity is inconclusive; it is a complex, multifactorial condition (Puhl & Heuer, 2009). The chronic nature of obesity develops as a result of multiple factors including behavioural, environmental, social, cultural, lifestyle

and genetic components (Spence-Jones, 2003). The adverse health risks associated with obesity impact not only both the individual and the society (Spence-Jones, 2003).

Increased burden on the health care system and the inability of the health care system to effectively care for people who are obese is increasingly seen in our society.

3.1.2 Stigma

The stigmas of obesity are ever present in multiple facets of daily life and are particularly prevalent in Western society. There is a notion that people get what they deserve and deserve what they get (Malahy, Rubinlich & Kaiser, 2009). This is evident in society with individuals who are obese as they are often socially disliked and are the targets of negative stereotypes (Hilbert, Rief & Braehler, 2008). According to Carels and Musher-Eizenman (2010), weight bias is widespread and the issue mimics racial discrimination. There is significant societal pressure to be thin, particularly for women (Carels & Musher-Eizenman, 2010). Research demonstrates that social problems of prejudice and discrimination toward individuals with obesity exist at work (Carr & Freidman, 2005), in public (Puhl & Brownell, 2012) and in interpersonal relationships (Carr & Freidman, 2005, 2006). The effect of stigma on aspects of life continues throughout the lifecycle (Camden, Brannan & Davis, 2008). Weight bias and prejudice towards the obese also exists in health care practice (Camden, Brannan & Davis, 2008; Spence-Jones, 2003; Teachman & Brownell, 2001; Twells, Knight, Alaghebandan, 2010), health care facilities (Howe, Wright, Landis & Kisuule, 2010; Kaminsky & Gadaleta, 2002), employment settings (Carr & Freidman, 2005), educational institutions (Canning & Mayer, 1966) and environmental spaces (Cutts, Darby, Boone & Brewis,

2009). Puhl and Heuer (2010) state that throughout history, disease has been considered secondary to “filth” and poor hygiene. Groups vulnerable to disease were blamed for their illnesses because they were immoral, unclean and lazy. Applied to today’s society, stigmas due to numerous psychological and physical consequences remain problematic for public health. Puhl, Schwartz and Brownell (2005) state efforts must increase to change the hostile societal environment towards people who are obese.

With respect to obesity, the stigmas create disparities and interfere with the implementation of prevention and management programs (Puhl & Heuer, 2010). Puhl and Heuer (2010) examined evidence regarding obesity stigma and its implications for public health. Research has well documented the discrimination and negative stereotypes toward people who are obese with the belief that the stigma may motivate persons with obesity to adopt healthier lifestyles. Puhl and Heuer (2010) however demonstrated through examination of existing research that weight stigma was not a beneficial public health tool for managing obesity or promoting healthy lifestyles. Paul and Heuer (2010) conducted literature searches and manual searches using search terms such as weight stigma, public health and health consequences of stigma. Results of the study found that the degree of empathy for an individual with obesity, for example, was significantly less than for someone with Alzheimer’s; as Alzheimer’s was deemed beyond the individuals’ control (Puhl & Heuer, 2010). The study similarly demonstrated that attitudes were improved and stereotypes reduced when the complex etiology of obesity (including genetic and biological factors) was emphasized, whereas, negative stereotypes were prominent when personal responsibility was highlighted (Puhl & Heuer, 2010). This message of personal responsibility is also the foremost message in the media (Puhl &

Heuer, 2009); the cause and solution lie within the individual. The strength of this message in the media only further justifies, and thus perpetuates, stigma as an acceptable social response.

3.1.3 Hospital

Given the increase in prevalence of obesity, a large number of patients who are obese are being admitted to hospital because of disease (e.g., heart disease, joint replacement, stroke, diabetes) associated with or worsened by their weight (e.g., Hofer, Kai, Decker & Warner, 2008; Spence-Jones, 2003). Lengths of stay and subsequent health care costs are greater for people who are obese compared to those of a healthy weight and there is also an increased risk of mortality (El-Solh, Sikka, Bozkanat, Jaafar & Davies, 2001). With these admissions there are challenges including increased staffing needs and specialized equipment; all of which contributes to the health disparity (El-Solh et al., 2001). Studies report that relationships with health providers and the patient with obesity are often poor leading to health issues being under-recognized and under-treated (Howe, Wright, Landis & Kissule, 2010). Care of the persons who are obese is considered demanding by hospital staff and respect for patients who are obese is low (Jefferey & Kitto, 2006).

There is only a small body of literature examining quality of health care among patients who are obese. In particular, there is limited research available examining the attitudes of health professionals towards people who are obese. Research has been conducted among nurses (Jefferey & Kitto, 2006; Poon & Tarrant, 2009); general practitioners (Hebl & Xu, 2001; Huizanga et al., 2009) and allied health staff (Campbell

& Crawford, 2000; Sack, Radler, Mairella, Touger-Decker & Khan, 2009). Challenges providing health care to persons with obesity identified in the literature include lack of appropriate equipment (e.g., gowns of appropriate size, equipment of appropriate dimensions and weight capacity) and lack of space (e.g., space to store and maneuver the equipment) (Jefferey & Kitto, 2006; Whitfield & Grassley, 2008). Previous work in this area has focused on the attitudes of those working with this population. Some studies report that health professionals perceive patients who are obese as unattractive, lazy and lacking in self-control (Jefferey & Kitto, 2006; Whitfield & Grassley, 2008). Research is lacking from the patients' view of the health treatment and care received.

Challenges to the care of individuals with obesity include models of care (Jefferey & Kitto, 2006), attitudes or beliefs (Brown, Stride, Psarou, Brewins & Thompson, 2007; Poon & Tarrant, 2009; Hebl & Xu, 2001) and training or experience (Ferrante, Piasecki, Ohman-Strickland & Crabtree, 2009). The (bio)medical model is predominate in hospitals when caring for the acutely ill, which consumes the concept of holistic care. Jefferey and Kitto (2006) stated that holistic nursing care includes emotional, psychosocial and spiritual aspects of care as well as the physical component of care and they researched this concept with nurses on an acute general surgical ward in Australia. Semi-structured interviews were conducted with ten nurses to explore the perceptions and experiences of caring for persons with obesity. From analyzing the transcript; themes and discourses were identified, including competing perceptions of obesity, medicine and nursing approaches to care and patient responsibility. Bariatric care or care of persons with obesity however often only deals with biophysical components and not with why the patient overeats or the social factors associated with obesity such as isolation or

unemployment (Jefferey & Kitto, 2006). With respect to the responsibility of patient's with obesity, it was argued that individuals shape their lives through their own choices (e.g., "just wonder why the hell they could not keep the weight off") (Jeffrey & Kitto, 2006, p. 80). Although judgments did fluctuate, medical dominance was the central factor shaping nurses opinions and perceptions of their work (Jeffrey & Kitto, 2006). The care became dominated by treating the patient and not addressing the responsibility of and concerns associated with being obese (Jeffrey & Kitto, 2006). There are significant theoretical and practical components to nursing, in addition to the medical discourse. New ways for nurses to assert themselves and new models of care for persons with obesity are needed in this growing area of health care (Jefferey & Kitto, 2006).

A similar study was conducted Brown et al. (2007) with the aim to investigate patterns of clinical practice, beliefs and attitudes of primary care nurses with respect to obesity management. A self-completion postal questionnaire was used to collect data, with a response rate of 72.3%; 96% of respondents were female. The participants were nurses and health visitors at primary care organizations in England. Results showed limited training in obesity management and negative attitudes toward persons with obesity, with negative stereotypes being rare. Attitudes were related to the nurses own body mass and to experience or training. The findings suggested that training in care and attitudes toward the obese person are needed.

Negative attitudes toward care of patients' with obesity was also demonstrated in a study by Poon and Tarrant (2009) which included undergraduate nursing students as well as registered nurses. A self-administered questionnaire was used, with a response rate of 52% among registered nurses and 81.8% among students (a convenience sample);

86.6% of the sample was female. Results showed that caring for a person with obesity was physically exhausting, and some were “disgusted” when caring for these patients. Registered nurses held more negative perceptions than students, but both groups perceived persons’ with obesity as lazy, unattractive and liking food. However, the degree of negativity depended on the BMI of the participant; those registered nurses or students with normal BMI’s were more likely to see the person with obesity as slow compared to nurses with a higher BMI. Similar to Brown et al.’s (2006) study, overall results of this study showed that nurses had negative attitudes toward persons who are obese and it may impact overall care.

Physicians attitudes toward the care of persons’ with obesity have also been shown to be negative (Ferrante et al., 2009); the highest prevalence among younger physicians. Ferrante et al. (2009) conducted a self-administered survey among 255 physicians with a 53% response rate. Difficulty performing physical exams, limited knowledge of weight loss diets and the belief that treatment was often ineffective were common practice based concerns.

Based on the literature review it is evident that obesity stigma exists in many facets of society and at many levels (e.g., healthcare, work, education and interpersonal relationships). As the prevalence of obesity continues to grow, there is a need to address all the challenges faced by individuals with obesity. Much of the literature that exists examines the beliefs and attitudes of others toward the obese but does not explore views or opinions of people who are obese themselves. Hospitals need to become equipped to work with this population and meet their unique care needs. Education in health professional curricula needs to improve because without knowledge and confidence to

treat obesity, only the primary medical issue or the admitting diagnosis will continue to be addressed (Ferrante et al., 2009). Obesity and lifestyle related behaviours are not effectively being addressed or managed within health care and subsequently health disparities continue.

3.2 Methods

3.2.1 Design

The aim of this qualitative study was to explore the experiences of the person's with obesity during hospitalization in acute care facilities in an urban centre in Atlantic Canada. To elicit personal stories and narratives, the current inquiry conducted in-depth, semi-structured interviews. Miller and Glassner (2006) recommend this type of data collection as experience often takes the form of stories/narratives. Additionally, this method is appropriate for this study as the use of interviews follows the natural discourse used by health professionals to gather information from patients (Green & Thorogood, 2009). The current study focused on listening and unobtrusively obtaining information, actively participating in the conversation, sharing discourse and collecting answers to questions to gather data through a journey between researcher and respondent (Hesse-Biber & Piatelli, 2007).

A phenomenological framework was used in this research. In using phenomenology the complex meanings of participants social reality can be captured (Green & Thorogood, 2009). This approach focuses on lived experiences and the meanings, interpretations and interactions associated with those experiences (Dionigi et al., 2011; Hesse-Biber & Leavy, 2004). The study recruitment process and protocol were approved by the

university and hospital ethics review board according to Canadian tri-council policy guidelines.

3.2.2 Recruitment of Participants

Study participants were recruited during a seven month period, from February to August 2012, from two acute care hospitals located in an urban centre in Newfoundland, Canada. Participants, 19 years of age and older with Class III obesity, were recruited using purposeful sampling while they were hospital inpatients; there was no specific length of stay (LOS) required. They were excluded if they were unable to provide informed consent (e.g., patients with dementia). Cognitive status was identified informally by the staff person who recognized patients as possible participants for the study. Patients admitted for gastric bypass surgery were not included in the study. There were no other particular treatments or surgeries that excluded individuals from participating. Patients' diagnosis was documented as severity and complications often correspond to increased LOS (McAleese & Odling-Smee, 1994).

Information about the study and participant inclusion criteria was circulated electronically among hospital staff. Hospital staff made the first contact with potential participants. Potential participants who were admitted to an acute care hospital for any medical illness or surgery were identified by a staff member (nursing and/or other health professional), and a letter was delivered to the patient requesting participation in the study. Potential participants were identified based upon a) their charts, which contained documentation regarding their weight and/or BMI or b) visually, based on their anthropometrics, with weight and height obtained and BMI calculated to determine if

criteria were met. An effort was made to include equal numbers of males and females from various socio-economic backgrounds.

3.2.3 Data Collection

Interviews were conducted within 12 months of discharge from hospital. Participants were interviewed in the location and at a time of their choosing. All attempts were made to secure a private environment with minimal distractions. An interview guide was developed which evolved and changed as data collection proceeded. The guide was based on review of the literature, experiences in the health care field and consensus among researchers (Table 1). After establishing a rapport with more general queries, the interviewer used probing with targeted questions to delve deeply into the specific concepts identified by participants. Following the first two interviews, emerging concepts were explored, questions modified and issues checked during subsequent interviews. Participant interviews utilized a semi-structured protocol. All interviews were audio-recorded. Some interviews were dominated by questioning rather than discourse when participants required frequent probing to elaborate on their narratives; other interviews were more conversational and involved minimal direct questioning. Some of the questions and the topic in general were sensitive in nature, so the interviews began with general questions to establish rapport, followed by more specific questions regarding their hospital experiences. Interviews lasted 60 to 90 minutes. Interviews concluded when participants expressed content that they had shared their story of hospitalization. Following each interview, notes were made about the interaction and the

process that were thought to possibly add value to the data. Notes were also made on the environment in which the interview took place and any distractions that occurred.

Table 1: Interview Components

1. Demographic Information Living Situation, employment status
2. Tell me about your typical day. How do you manage your personal care and activities around the house? What kinds of adaptive aids or equipment do you use to help you manage your daily routine more independently? How useful are they? How is your driving? Tell me about the things you do at home. Outside of home.
3. Tell me about your hospital stay. How long were you in? Why were you admitted? Have you had many admissions to hospital? Tell me about the care you received. How adequate was it? How did you feel about the equipment you used? How did it meet (or not meet) your needs? How were you treated by the staff and other patients in the hospital? Did you feel you were treated differently because of your body type? How did you feel about the communication between you and the staff?
4. We would like to know more about your supports from family and friends? Who do you live with? How do they help you in your daily routine? How do other people outside your home or paid caregivers help you?

The primary investigator was both athletic and a health professional (occupational therapist). To protect against potential stakeholder bias the interviewer took extensive field notes. Field notes and the interview audio tapes were simultaneously assessed for reflexivity. Reflexivity was necessary for detection of emotional reactions related to the participants' narratives. Hesse-Biber and Leavy (2004) define reflexivity as the recognition on the part of the researcher that research is a process that contains power dimensions. In seeking perceptions of experience, emotion was further explored with

additional questions during the interview or simply noted for exploration during analysis of the data. Memo writing was also used to examine personal biases (Punch, 2000).

The number of interviews conducted depended on the information gathered. Interviews were conducted to the point of saturation of data. The intention of saturation is to keep sampling and analyzing data until nothing new is generated (Greene & Thorogood, 2009). Recruitment and interviews ceased when no new concepts were obtained from the interview content.

3.2.4 Data Analysis

Audio-taped interviews were transcribed and checked against field notes with identifying information removed. Themes evolved and were identified in the first transcripts through a process of open coding (Punch, 2000; Neuman, 2007). According to Punch (2000) opening coding is a first level of analysis which involves breaking down the data to highlight important ideas. Development of themes began during the interviews themselves as topics were discussed by the participants; however clarification of themes came with review of transcripts and each subsequent interview, as similar ideas were shared by participants. Co-analysis occurred as the interviewer shared generalities with other participants and asked for their perceptions (Punch, 2000; Neuman, 2007). To guard against bias, three content-dense transcripts were reviewed and independently coded by a co-researcher (Punch, 2000; Neuman, 2007). Codes were then compared and coding scheme developed based on consensus between researchers.

Thematic content analysis was used to identify similarities and differences across all data (Green & Thorogood, 2009). The aim of this type of analysis was to present the

key elements and categorize the participants' accounts in ways that could be summarized. This was a comparative process to classify themes that were common or recurring. The open codes were then clustered into more focused ideas with second level ideas that related back to the main theme (Punch, 2000). The relationship between themes and subthemes amongst all the participants allowed for a holistic view of the findings.

3.3 Results

3.3.1 Participants

The nine study participants, ranged in age from 36 to 70 years. BMI's ranged from 43.2 to 56.5 with body weight ranging from 111 to 164 kilograms. All nine participants choose to be interviewed within their own homes. Although none of the participants were working at the time of the interview, three hoped to return to work, two were retired and four were unemployed. Eight participants resided in their own home or apartment while one subject resided in a personal care home. Five participants reported using formal home supports and four relied on family for assistance as needed. Families also assisted with transportation. Reasons for admission to hospital varied and included joint replacements, cancer, congestive heart failure, pneumonia, diabetic ulcers and myocardial infarction. Five participants reported only a small number of admissions to hospital, whereas the others had frequent visits related to co-morbidities.

3.3.2 Themes

Analysis identified two themes that influenced the perception of hospitalization and obesity in general: communication and the environment. Participants described their communication with nurses, physicians and allied health staff during hospitalization and

how it affected their treatment. The impact of the built environment and environmental objects was also defined by the participants with discussion about stairs, room space and seating. Space and equipment in the hospital environment and the barriers associated with access and availability challenged participants as they worked toward the medical and functional status required for discharge home. Overall results show that most participants reported a good experience during their admission to hospital; with some specific exceptions where they spoke of several aspects of care that were not satisfactory.

3.3.2 Communication

In this study communication was defined as both the verbal and non verbal conveyance of messages. In health care communication in the form of written documentation in a medical chart is essential to the care of a patient. This allows information sharing amongst members of the interdisciplinary team. For patients however the primary source of information is verbal; assessment and test results are provided to the patient verbally by the corresponding health professional. As with communication in general, problems can arise with this form of information sharing. There may be language barriers between patient and health professionals (knowledge appropriate communication) or ambiguity of words and phrases or differences in individual linguistic ability (i.e. issues understanding jargon). A common problem in medicine with its complex terminology and time constraints is how effectively the message is being communicated (or if it is even communicated at all) (Jallinoja et al., 2007). Other barriers may include physiological barriers (i.e. ill health, poor eyesight, poor hearing), the presentation of the information and attitudinal barriers. Participants

described their communication with nurses, physicians and allied health staff as satisfactory however many were disturbed by instances where they felt as though they were being talked ‘about’ rather than being talked ‘to’ regarding their health status. In this section, communication with a variety of hospital staff is discussed providing specific examples of the barriers to communication.

3.3.2.1 Nursing

In this section communication with nursing staff is discussed by the participants in terms of the efficiency and effectiveness of the information shared. Of all the professions working in the hospital, participants stated that they had the most contact with nurses.

Marjorie began telling her story by saying that the nurses neither did little to help during her admission nor communicated much information regarding her illness:

And I was down there, there were 4 people on the ward and they put me in there and all they did was give me a pan of water, never asked to wash my back or did I need anything done....and I got myself, whatever I could do and I got ready and they took the water and that was it, they never did nothing.....except pass me my medication and that was it.....

Darren shared similar concerns, feeling that the staff did not have time to communicate with him. Nurse to patient encounters were brief and possibly not heard:

even my meds, like they called out and got my med list from [local pharmacy] and I told them that I am on Vitamin D and Calcium which I got to have, and they were like “oh we will get them ordered,” but they were never ordered, my wife just brought them in...

Darren was concerned about missing these medications as they were prescribed by his rheumatologist to reduce side effects of some of his other medications. He felt that his concerns appeared to be of little importance and there was no further communication

about his request for them or why the medications were not provided. From Darren's point of view the staff did not bother to help or to communicate because his wife was there to assist him.

It was noted in all the interviews that the participants realized the nursing staff were busy and had an enormous workload. For some participants the business of the nurses was not a concern; they just waited and accepted that the staff was obviously helping other patients and their needs would be tended to as soon as possible. Clayton however expressed feelings of anger and rage at the lack of efficiency and thought response time "*was just not good enough.*" He offered a different perspective: "*my job there was to maximize as much as possible the benefit I was going to get from the procedure, you have to be selfish or else you could lie in the bed and be everybody's good friend...*" He was the only participant that spoke of the nurses' work as unsystematic, disorganized and imbalanced. "*When I absolutely needed somebody they would be out gossiping at the station.*" He described himself as "*captive of the system,*" and the lack of response from the staff led to frustration. "*You can't walk out you know, which is what I would have done in another instance.*" With his background as a health professional (as well as his wife's), he had knowledge of hospital administration and described the problems as being at an organizational level. "*People in their ivory tower up there....and not having a clue what was going on, one person reporting to them and it's a....they cut out the middle managers to a great degree...*" Throughout his interview, Clayton expressed concerns about disorganization and lack of communication, between staff and between patient and staff. "*People don't introduce themselves either you know, so you don't know who is telling you what.*" For some participants like Susie, who had a positive

hospital experience, communication from nursing staff produced a sense of comfort when some of the personal care she required made her feel embarrassed. Susie also felt well informed upon discharge about medications and follow-up appointments which she voiced as important to help minimize the need for readmission.

Two of the participants, one who had frequent admissions and one who had an extended admission, shared similar experiences to each other while in hospital with respect to communication and interaction with the nursing staff. Betty described herself as a “*frequent flyer*” at the hospital. Over the years, Betty had multiple admissions for her congestive heart failure and ongoing respiratory issues. As she aged and her breathing became more and more compromised her admissions increased in frequency. As a result of several visits to the hospital she was known by many of the staff; consequently she felt a more personable relationship developed. When asked about the length of her most recent admission, she said “*I am in that often I am getting mixed up now.*” She described a professional patient-staff relationship but with interactions that seemed more understanding and friendly. Betty felt that staff was familiar with her needs and preferences and she was aware of the inpatient/hospital process. She “*knew they were busy and would tend on her when there was time.*” For example, Betty, a very sociable person, was quarantined after contracting an antibiotic resistant infection and she felt happy that the nurses would “*pop in*” and check on “*how she was doing.*” Betty felt her interactions made the time in hospital more bearable. For example, she commented that she felt contagious when people came in all “*dressed up*” (in hospital gowns and masks) before a staff member took the time to explain “*this thing I had and how I got it,*” emphasizing the importance of communication.

The situation was similar for Walter due to his extended length of stay. He described how the staff became familiar with his daily routine; they learned about his family and his circumstances. He, in turn, felt he developed a more personal relationship with the nursing staff; learning about who enjoyed their job and who did not, along with aspects of the nurses' lives outside the hospital. Walter talked about being a private person, preferring to have space and to not have a lot of people around which was in contrast to his wife who was very social. While in hospital however he shared stories of being "*trapped*" in his room and, although typically not a social person, he welcomed visits from the nurses and "*started a conversation with anyone who came in the room.....I think that it was coping.*" He spoke of adaptation and having to adjust to a lengthy stay in hospital while his wife was ill in another hospital. Unlike the other participants, who spoke of communication with nurses primarily from the perspective of efficiency and effectiveness of care and provision of medical information, Walter talked about the compassion they had for their jobs and how well they treated him. "*Even the older ones that were nursing for a while, you could not get a bad comment out of them, they loved their nursing.*" Walter however spoke not only of the relationship/friendship he had with the nurses, he spoke of nurse to nurse interactions during teaching around particular skills for example in the use of a special dressing for treatment of his diabetic foot ulcer.

Rapport and trust had been established due to his length of stay:

...I said Mary had me adopted (laughter)...and she would have the youngsters in (student nurses), stuff they would never get out of a text book . . .there was times when there was 15 people in my room, between students and the regular nurses and all that crowd, seeing what was changed from the last time it was changed and all that kind of stuff.

With a non-healing diabetic foot ulcer, Walter was a tremendous risk of needing an amputation. Walter had aspirations of walking out of the hospital and returning to independent living. He was patient and hopeful throughout the process and he was also staying strong for his children while they simultaneously dealt with the hospitalization of their mother. The strength he had was in part due to the nursing staff. *“The respect I had for these people, because . . . they just did not give up.”* Walter felt the staff went above and beyond in managing his medical needs, assisting with his personal care and in communicating with him as a person; he quoted one nurse as saying that *“spending a few minutes with Walter, would help in facing the day.”* Walter was a pleasant and cooperative gentleman who expressed a desire to get well and be discharged home.

3.3.2.2 Physicians

Many physicians verbalize test results or diagnoses to a patient but seldom is there opportunity to clarify or confirm what is said before the physician has moved onto the next patient. Several participants found it disconcerting that physicians often travel in groups speaking amongst each other but not communicating between the group and the patient. Marjorie explained *“then they always have 5 or 6, they have 5 or 6 with them and they are always referring . . . you know talking to all them about you as if you are not even there . . . now Ms. M needs this and Ms. M needs that . . . but they never told me what was going on with me.”* Participants described how since they were uninformed about their care, family members were challenged to obtain updates from doctors who were seldom available. Susie found that once she could target one person in the physician group, communication was improved: *“with the entourage, they were coming at ya in all*

directions sort of thing, but one-on-one . . . I found a whole lot better.” She explained that there was one physician resident who would sit down to explain things but with the group they would talk amongst themselves (“*do that or increase this or don’t give her so much of that . . .*”) using words she did not understand and from her point of view lacking in explanation. Beulah also spoke of the group visits as being quick and brief with little opportunity for information sharing.

Several participants described their interactions with their physicians as being positive and informative

Lisa: He came in everyday, now it could be in the evening; he came in and held my hand, very nice to me, kept praising me up. He actually told me that [he advised] the lady next door [in the adjacent bed], “I want you,” he said . . . “to be” . . . what is the word he said, “I want you to be encouraging and I want you to get her on the go” . . .

Interviewer: so Dr. M saw you every day?(said with much surprise)

Lisa: whenever he had a chance, I had never ever asked for him . . .

Lisa admitted the daily visits from the surgeon alleviated some of her anxiety and nervousness and provided extra encouragement she needed to get back on her feet. It is interesting that Lisa and Clayton, although they underwent the same surgery (total knee replacements), described completely different hospital experiences. Lisa’s surgeon visited daily, whereas Clayton stated that “*finally I just absolutely insisted that I just had to see the surgeon.*” Clayton felt he had questions that remained unanswered and that he wished not to direct to the nursing staff because he felt they were inattentive to him when he rang his nursing care buzzer. He stated that although he saw the medical staff visit and gather in the mornings, he felt that the hasty visit was not the right opportunity for him to find answers to his concerns about his surgery and its outcome.

they came around and did rounds in the morning, the orthopedic people and that was pretty how are you today kind of thing for 2 days and finally I said I need to know where I am with this, what the surgery outcome was, was there any trouble and the other thing I was concerned about was, that I developed anemia both times when I was in the hospital . . .

Debbie described how it was important to her that her surgeon was compassionate and treated her with respect when she was dealing with a serious diagnosis of ovarian cancer requiring a total abdominal hysterectomy.

Debbie: They, from the very beginning they, well the number one thing is, well the admission and everything went well there and the surgery, I mean I had a fantastic doctor to start with . . . she treated me like a human being and of course we had to go through all the anything that could happen like with any surgery and the fact that I was obese and of course I knew all the risks were . . .

Interviewer: the risk factors were . . .

Debbie: . . . higher . . . she went through all of that with me so, I did get some of the, I did get some of the complications develop, I know that is through, because of my weight and but I think, you know everything is going to be okay, she went through all that, but not once with her, I don't know if you want to know about the doctor or not, but not once did she make me feel like any less of a person because . . .

Debbie described how she felt relieved and grateful that her surgeon, despite not working that day, attended to her post-surgical incision issue in the hospital emergency department potentially averting further surgery. She outlined multiple instances of how effective communication during her health crisis lead to better health outcomes. Betty was also pleased by the physician that was managing her care during her admission to the hospital. Despite frequent admissions for the same chronic condition, visits from the physician were still significant to her. Although the medical staff did not see her every day, she was pleased with the interactions that did take place and felt positive about the care that she received.

Walter, who had a very long admission to hospital with multiple surgeons involved, spoke not only of the care and effort to salvage his foot but his concern about what he perceived was the “politics” between surgeons while determining his required care. He described how the debate regarding the care of his foot (wound care, skin grafts or an amputation) seemed to take place between surgeons rather than with him.

You know there was a big uproar then because Dr. F was supposed to do it, but for whatever reason Dr. T jumped in. That was politics, all politics, right, and then it was back to Dr. M and then back to Dr. T, we got to cut your toes off . . . turning black.

Walter felt because of the complexity of his case and the risk of losing his foot that the communication (written and verbal) between patient and physician and between/amongst health professionals was of utmost importance. His narrative however tells a story of poor communication between all involved.

3.3.2.3 Allied Health Professionals

Participants described contact with allied health professionals (occupational therapists, physiotherapists, psychology and dietitians) less frequently than they did nurses and doctors. While most participants spoke about their limited involvement with allied health staff during their admission, Darren spoke of how the occupational therapist, but not physicians and nurses, helped him overcome the limitations imposed by rheumatoid arthritis. *“You know the only person in the medical field that ever helped me with my socks was S, but I am telling you, you get up to see a rheumatologist and these are doctors that are supposed to know that you can’t do it.”* Darren voiced that there is a lack of awareness and acknowledgement of the day to day limitations of a chronic disease

[from the physician] and that it was the other health professionals that helped him to manage his daily activities.

Lisa shared how that even though she was prepared for the post-operative routine, she felt fearful when getting out of bed for the first time following her bilateral knee replacements. For patients receiving joint replacements the physical and occupational therapists become involved on the first day following surgery ensuring mobility and function are initiated as a component of discharge planning. When the day finally came, feeling nervous and uncertain, Lisa reported, “*they [the therapists] did not lose their patience . . . they remained calm, they were very nice.*” She felt that her preferences were considered:

they were just trying to encourage me . . . and I knew that and you know what they were very patient with me and I said you know . . . right now I really can't, I really can't, just give me a minute, just be patient, just wait and they did and then I did, so they were patient, they did not push.

Lisa went on to report that when she eventually returned home her oversized walker made it difficult to access her toilet: “*there was no space for nothing.*” Bariatric equipment is larger (so as to meet the weight capacity requirements), subsequently reducing accessibility. She described how she called the therapist at the hospital and they problem solved and discussed on the phone how she could access her bathroom and toilet in privacy.

. . . now when I came home that day I went to go into the bathroom with the walker and I could not get it in, ... so I phoned the hospital right away to speak to the OT, she called me back and I told her, I said what do you think, ... I did not know what my limitations were . . .

Most participants, especially those who described themselves as being independently mobile, did not report interacting with allied health professionals. For some participants,

they reported brief but positive encounters with therapists. Susie was someone who was independent before coming to the hospital so she just needed minimal therapy to help get her moving. *“A physiotherapist came there too, to help me walk right, because I was in bed for 10 days and you know if you are sitting down watching television for an hour, your legs get . . .”* She talked about how as she got better medically she did more on her own.

she helped me (physiotherapist) for a day or 2 I think, probably 15 or 20 minutes and that was okay, because I had to take it slow right, so after that she left the walker there in the room, after that I would take the walker on me own, and go for a little walk, then I would sit in the wheelchair there on the side of the corridor, I would sit down and take a little rest and each time I would do a little bit more, a little bit more, a little bit more . . .

Similar to Susie’s experience, Debbie described feeling weak and frustrated with her inability to move around following her major surgery *“I kind of had to do everything myself from the beginning to get up and for someone who just had major abdominal surgery like I did . . . it was just not going to happen.”* The physiotherapist was therefore consulted to help with her mobility: *“oh yeah I had physiotherapy see me and I had to get out and walk a bit and before I left I had to do stairs . . . to make sure, even though I never had stairs.”*

Betty described how her breathing and requirement for oxygen made it difficult for her to climb stairs following her discharge from hospital. Although she reported seeing a physiotherapist, she felt at times their goals were not the same. For example, she could not understand why they practiced *“three steps and I am doing ten at home.”* She enjoyed seeing physiotherapy and had had the therapist before, *“I have had L. before....she is nice.”*

For Clayton, he prioritized therapy because he saw it as a way to “*maximize my outcome*” after his knee replacement. However he felt that his recovery may have been impeded by lack of specific communication about the timing of his therapy.

I don't want to seem totally critically of everybody . . . the physiotherapy people were good, they came when they could and I know they were very busy, problem is, they would say make sure you take your pain medication because it helps an awful lot.

I would ask for it, ...I was not always aware of when they would show up, ...but there was no correlation between the pain medication and the actual [therapy], sometimes 3 hours later that they came to do . . . you know with codeine . . . or could be 5 minutes after . . . it takes at least half an hour for it to convert to morphine before it is any use to you whatsoever . . .

For most of the patients, acceptance (not approval) of the system was apparent but for Clayton, who was a retired health professional, the poor communication and disorganization were not acceptable. Clayton described taking matters into his own hands; by involving the nursing supervisor because he felt “*timing is [was] just a complete tangle.*” However, he reported that there was no response to his concerns, and “*the scattered way in which things were done*” did not assist in his recovery.

For Clayton physical therapy, with an emphasis on exercises and mobility was crucial to his recovery but for Walter therapy could have been detrimental resulting in further damage to healing tissues. Walter described his therapy needs as more emotional in nature and related to coping. Walter benefited from psychological counselling in which communication is the method of therapy. “*The doctor was saying you might have to lose that foot . . . now my two kids were a bit concerned about how I was going to be doing, psychologically I was going to suffer.*” With his medical issues, declining health of his wife and selling his home, Walter said of his psychology support, “*I don't need this,*

but I was really glad after.” Sitting one on one with a trained professional helped him explore his stressors, increasing his strength for coping with the physical ailments related to his poor health.

Despite the potential role of dietitians in the management of obesity, participants described few interactions with these professionals. A dietitian did not assess Marjorie, Clayton, Lisa, Susie, Debbie or Walter during their admissions. Betty also did not see a dietitian during her admission but unlike the other participants, who never commented on this issue and just “*shrugged*” it off like it was no big deal, Betty said “*no, I never saw a dietitian; that is strange I didn’t either.*” Darren, who was one of the few participants who saw a dietitian, had little to share about the experience because he felt it was very brief and not very informative:

we had a brief visit, more like a social, hello, got to go, she was in a hurry... so she gave me a run down and apparently she told me that Honey Nut Cheerios is a good breakfast cereal, but the other dietitian, told me, no, no it’s not.

3.3.3 Environment

Environment for the purpose of this research was defined as the circumstances and conditions that surround us. The totality of these circumstances includes the combination of external physical conditions and the complex social and cultural conditions that affect the nature of an individual or community. The environment also holds the distinction that we can choose the environments in which we engage, both physical and social, and we can choose the objects that we place in the environments we call our own. In this study, the environment was a product of circumstance in both the home and the hospital and included the built or structural environment and objects in the built environment.

3.3.3.1 Built Environment

The term built environment refers to the human-made surroundings that provide the setting for human activity; in this case the buildings (hospital or home) and supporting infrastructure (Berke, Koepsell, Moudon, Hoskins & Larson, 2006). The data indicated that for many of the participants' aspects of the built environment limited engagement in the day to day activities of life. The following sections outline the challenges participants faced in the built environment including stairs (both at home and in the hospital), hospital rooms and objects in the built environment.

Stair Climbing: Stairs were consistently reported as a barrier of concern for participants, whether the stairs were outside or inside a building or home. Participants described concern about the stress that stair climbing placed on their breathing and painful joints. For example, because of stairs, Marjorie was no longer able to access or enjoy the privacy of the lower level of her home where she had a bedroom and bathroom while living with her son and two granddaughters. Because of increasing difficulty navigating the stairs following discharge from hospital, her activities and everyday living became limited to the small area on the main floor, "*now, but I said to him [my son] I should be able to walk down over the stairs now, he said no, you are not going down stairs.*" So she remained confined to the main floor where she longed for her privacy. There were also stairs to enter the home which were in need of repair and subsequently she limited her time outside the home due to the risk of falls.

Darren faced a similar environmental barrier with a steep set of front steps to access his home. Once inside everything he needed was on the one level and avoided going to the basement of his home, but for outside activity, he had no choice but to use the stairs.

He spent most of his time at home; especially when his joints flared as the associated fatigue was debilitating. When asked about going outside his home he responded “*I try to . . . go to the dog parks and stuff . . . but believe it or not, I find it is easier to walk on a treadmill than on terrain because of my ankle movements, but I try to get out.*”

For Lisa stairs were a threat not only a home but also at work. Although the stairs to her apartment were somewhat of an issue the stairs at her workplace had much more of an impact on her function, resulting in scheduling changes to minimize her need to use stairs.

Well I had to change my time frame of work, because in the evening, closing up time, I used to close up at 6pm, so I was the last staff there, so I was upstairs for a half an hour with two or three children and in the evening downstairs . . . so to climb the stairs was just almost impossible.

. . . I would have to turn off the lights downstairs and the children would all go up and then I would have to lock up the door downstairs and down over steps then to the car in the evenings, it got to be winter time and I said you know what this is too treacherous for me, so the co-worker changed schedules with me, so that now I leave at 5:30 and she closes at 6:00, so I was not left alone

Lisa was grateful that her workplace made such accommodations and she looked forward to returning as soon as possible.

For Clayton, stairs were an issue for reasons similar to Darren (arthritic joints), so he tended to avoid them. Clayton lived in a two storey home, “*ahhhh we got an elevator hey . . . so it is manageable in that regard.*” He was one of the few participants who reported having the financial means to overcome barriers and modify his home. Betty, on the other hand, felt trapped in her own home, “*I just want to go out and go shopping . . .*” As an apartment dweller with two sets of steps, the only time she leaves is when she is taken down over the stairs by paramedics and transported to the hospital.

Hospital Rooms (Private versus companionship): Participants related how being assigned either a private or multiple bed room impacted their hospital experiences. For some patients the private room was preferred during a time of illness, as it allowed families to visit without interfering with the care and health of others. From the data collected it is evident that some patients however prefer the ward room as it offers companionship and someone to converse with especially if they were older in age and personal visitors may be less frequent.

Some participants such as Debbie spoke of what she considered “*luck*” to be able to have a private room throughout her admission:

yup, and I don't know how I would have done it on a ward with other people I mean, I am not a private person per say but when you are sick and you have to get up 5 or 6 times a night and you have to ring the nurse 5 or 6 times a night and you need to talk about things, you need to ask questions, who wants everybody listening . . .

and it is not just them it is their guests and their visitors and their . . . everybody knows what is going on right . . . you get out of bed to walk to the bathroom and the whole room is filled with people . . . I don't know, if I had to go through that experiences it would not have been pleasant . . .

Walter's comments were also consistent with a preference for a private room for personal reasons.

. . . so for the whole time I was there I was in a single room, I was to[by] myself, I had my radio on 24/7 . . . I like being by myself . . . [if he shared a room] maybe they would not want the radio on all the time and I could stay up until 2 o'clock in the morning reading

For Walter the private room had double the significance, he wanted one as a private person who liked to keep to himself and he also wanted his wife to have one so that she could be at peace during her last days. He expressed the importance of dignity in healthcare, especially during the end of life, which he felt was lost for many during

hospitalization. Also Walter, like Betty had a medical issue that warranted a private room.

Beulah also spoke about having a private room. With the bed, bedside stand, bedside chair, wheelchair, commode and so on, it was still “. . . *how do I get in here.*” She mentioned during a previous admission being in a ward room and she did not recall how it ever worked as they offered even less space for the patient, equipment and visitors to move around. Both Betty and Beulah preferred multi-bed rooms in order to “*mingle.*” Betty in particular, found the opportunity to socialize a welcome change from her relative isolation at home.

Lisa explained that initially she wanted to be in a private room, “*but they did not have one available, so they put me in a ward and I was happy.*” This was similar to Beulah in her desire to interact with others: “*I like to have company. I was in a ward room and got along famously with everybody . . . made good friends there.*” Lisa talked about the disruptions in the middle of the night and the moaning and groaning from other patients in the room, but it was not an issue for her, “*you know what I just drifted back to sleep.*” Marjorie did not speak of a lack of space as an issue or having company as a benefit in a ward room, rather she focused on the disruptions and the difficulty getting rest. Susie described how she shared a room with one other person, so there was reduced privacy but not the chaos of a ward room. At one of the hospitals she was admitted to a semi-private room. She commented that the room could have been “*double the size and it would have been a lot better.*” The rooms, in particular the ward rooms, were so small that everything had to be shared and there was minimal privacy.

Objects in the Built Environment: As defined above the built environment includes the man-made structures in which we perform our everyday tasks. To complete these tasks we use objects or things placed within these environments. For the purpose of this research the objects in the built environment include wheelchairs, flimsy seats and beds. For persons with obesity utilizing the built environment is sometimes challenging due to limited accessibility and walkability, without the proper objects, day to day living becomes more demanding.

Wheelchairs. Wheelchairs were another item discussed by some of the participants. For some participants, wheelchairs were temporary measures used in hospital for transport to and from tests. For others, wheelchairs were a means of mobility both in the hospital and at home. Darren was transported in a wheelchair from critical care to a regular hospital ward and Betty used a wheelchair to be transported to the bath tub for personal care. Otherwise both these participants walked within their rooms.

Walter also used a wheelchair during his stay and he would sit in it daily at his bed side and would occasionally propel himself down the hall when he felt well enough. “*I had a great big bariatric one.*” He explained that because it was so wide that he had difficulty reaching the wheels, so he took the armrests off so he could independently propel the wheelchair. Walter, a new wheelchair user due to his injured foot, felt grieved by the fact he was forced to move to an assisted living facility from his inaccessible home. Although he could access the outdoors grounds and a walkway around the assisted living building, moving about was not without challenges. To access the main level of the home, where the dining room was located, Walter had to use an elevator in his wheelchair and because of the width of the wheelchair compared to the elevator door, he

said, “*I calls it the knuckle buster, if you don’t watch what you are doing getting in, you will regret it for sure.*”

Beulah, who reported using a wheelchair for the past eight years, felt a new sense of freedom in her new home, “*this is the first house that has ever had a ramp.*” For Beulah, the wheelchair provided her with more comfortable transportation. Even though she had lost weight and could be independently mobile, she preferred to mobilize around the environment from her wheelchair as it was less stress and exertion on her body. Also, in her new home the widened doors allowed her to access the kitchen and living area from the comfort of her wheelchair. Both Beulah and Walter described their wheelchairs as suboptimal in both design and size. Beulah permanently removed the armrests so she could fit while Walter “*squeezed*” himself in tightly and uncomfortably between his wheelchair armrests. Beulah explained that if she had the recommended size wheelchair she would be trapped in her room. Walter similarly stated that if his chair was as big as it should be he would not be able to access the dining area of the personal care home. Walter stated that this was a challenge for the therapists and staff working with him as his physical needs dictated one thing, but the built environment dictated another.

Flimsy Seats: For the people with obesity, seating with a larger weight capacity is necessary to safely support the individual during any task that may involve sitting. Sitting or seated tasks range from toileting, sitting to rest and recover or sitting for the purpose of transport from one area of the hospital to another.

Darren was one of the only participants to speak of his experience in a critical care unit. With the open concept of the unit, walls and other barriers are eliminated so that critically ill patients can be monitored at all times without staff being immediately at

bedside. Due to the open concept; washrooms which would be behind closed doors, are not available to patients. Darren related how he was amused to find that in the intensive care unit, there was no patient washroom and he had to use a portable toilet they folded out:

I said to the lady, is that safe, she said the nurse said, oh yes, I did not trust it, that is fine, I will suffer, but no one offered a commode or anything, I mean I am looking at that, going there is no way I am sitting 350lbs on that, you know what I mean, that was a bit awkward, but you know . . .

I mean there was nothing, it was hooked onto the door, so I was thinking if I did sit on it, I would be down in a pile, and room is flooded.

Darren voiced his concerns, but an alternative was not offered so he had few options, “*my wife was there a lot, you know, so she helped me get cleaned up and stuff like that.*” Both Walter and Clayton also expressed frustration and embarrassment about what they perceived was as inadequate toileting options and “*cursed on the commode*” that was initially provided; “*almost like two outhouses.*” Eventually though “*they brought me a reasonable one.*”

For Beulah, an unsuccessful transfer from her wheelchair to her commode at home precipitated her most recent hospital admission. Beulah on the other hand relied on the commode both at home and in hospital. Being primarily a wheelchair user, bathrooms were often inaccessible. Despite the mishap at home, while in hospital she continued to use the commode without an issue, standing and pivoting independently from her wheelchair. Lisa required a wheelchair following her knee replacements but found the hospital washroom too small to maneuver the chair and so she was forced to use a bedpan or commode. “*The bathrooms were okay but they were small, there was kind of a knack for getting in to them, especially with the IV pole.*” Betty was also mobile enough to use

the bathroom and was able to do so throughout her admission. She did however comment that the rooms were small, so she just held onto the wall as there was no room for equipment.

Chairs: Chairs in general were an apparent issue, with availability, size and comfort being some of the concerns. Debbie spoke of the chairs being old, not suitable to sit in and being in scarce supply especially for visitors:

There is not even chairs for visitors . . . there is not even a chair for someone to sit on . . . that is a fact . . . if you are in a four bedder, a ward, the chair goes passed around from bed to bed, okay I am leaving now so you can have this chair . . . I mean it should never be that way . . . that is sad, and I am not saying if you have six visitors you should have six chairs . . . but you should be able to accommodate one visitor and you end up sitting on the beds . . . if you are in . . . if you got a family member in there and you are in there for hours . . . you need to sit once in a while.

Debbie felt the chairs were inappropriate but regardless of this there was no space for chairs for either the patients or their visitors. Clayton related how he needed a suitable chair in order to do his knee exercises and subsequently improve his mobility which was necessary for a successful surgery. But given his size, there was limited availability of bedside chairs. Bedside chairs were also an issue for Beulah, who resorted to just propping herself on the edge of the bed as the chair in her room had armrests on it, “*a chair with arms is grand if you fit in it.*” Pointing and holding her abdominal region, she stated “*you do get stuck under the arms especially when you have this.*” Beulah stated that she needed a chair without armrests so that her abdominal area could be comfortable.

Inappropriate Beds: Beds were another common issue discussed by the participants, in terms, of size, comfort, and ease of transferring in and out. Darren talked about sleeping in a chair when he was transferred out of the critical care unit:

it was one of those three pocket mattresses, . . . the middle pocket was gone and I got into that, so I ended up sleeping sitting up in the chair just looking out the window, because I was pretty restless, I knew there was a pretty good chance that I would be getting out the next day....it was a bad bed, make shift I think to get me out of critical care.

Beulah reported that she was pleasantly surprised when emergency room offered her a larger bed once she arrived on a obviously undersized stretcher they “*did something I never expected them to do . . . they went out and got me a different bed.*” However, upon transfer to her hospital room she felt alarmed by her bed which she said “*creaked and cracked and cracked and creaked.*” Clayton described his hospital bed as a “*booby trap.*” Although she never felt like she was falling out, Susie had similar issues with the bed as Clayton: “*it was hard, very hard and I used to always go to the right.*” Susie chose not to complain because she felt that if she was not overweight it may have been more comfortable for her as her smaller room-mates never complained about nor had difficulty sleeping on the beds. Lisa did not have as much to say about the beds as the others but did talk about the nylon surface of the mattress and how hot and sweaty it was. For Walter the comfort and adjustability of the bed was not an issue, but the noise level reduced the quality of his sleep.

3.4 Discussion

Bariatrics is the branch of medicine that deals with the causes, prevention, and treatment of obesity (World Health Organization, 2004). The field encompasses dieting, exercise and behavioural therapy approaches to weight loss, as well as pharmacotherapy and surgery. Subsequently, obesity is considered a disorder that is a result of genetic, behavioural, environmental and physiological factors (Sack, Radler, Mairella, Touger-

Decker & Khan, 2009). For this population, health and societal factors interact to add to the complexity and insidious nature of obesity. Exploring these factors is important to the proper prevention and management of this growing health concern. As a relatively new branch of medicine, the research on the barriers to healthcare for the person's with obesity is limited. The research focuses primarily on the medical model of care and the challenges the faced by the health professional in working with this population. Predominantly the focus is on attitudes and discrimination toward this group as it is believed by many health workers that the problem is self-inflicted (Thuan & Avignon, 2005; Poon & Tarrant, 2009). Very limited research exists on the patients' perspective of their obesity problem (Evans, 2009; Jay et al., 2010). Therefore the purpose of this study was to: (1) explore the obesity stigma that exists in healthcare from the patients' perspective and (2) add to the limited body of knowledge on patient's perceptions of the quality of care for obese persons. The study used qualitative approach with semi-structured interviews of nine subjects who were identified during hospitalization in acute care and were interviewed upon discharge.

3.4.1 Obesity Stigma and the Perception of Quality of Care

Literature states that there is a reduction in quality of care and decreased utilization of services because of the lack of respect and discrimination toward persons with obesity (Chambliss, Finley and Blair, 2004). Participants in this study believed that they deserved respect and to be provided with good quality healthcare. Congruent with existing literature participants in this study received treatment of the presenting problem and not the underlying contributors to these secondary chronic issues. The participants'

spoke of the admitting diagnosis being treated followed by discharged; there was no education on weight management or overall strategies to increase health or well-being. Padwal et al. (2012) stated that weight management strategies are infrequently delivered in the primary care setting for reasons such as lack of training, lack of access to multidisciplinary teams and a paucity of effective treatments. Howe, Wright, Landis and Kisuule (2010) reported similar findings, stating that hospitalist providers do not regularly document obesity as an issue in their assessments and subsequently do not initiate treatment plans.

Two main themes emerged from the participants in this study: communication and the environment. Participants described the communication with various health professionals during their hospitalization and how it affected their treatment. The impact of the hospital environment and the equipment and the barriers associated with access and availability respectively challenged participants as they worked toward the medical and functional status required for discharge home.

Communication with nursing was seen by the patients as an integral part of hospitalization. Participants described their communication with nurses, physicians and allied health staff during hospitalization and how it affected their treatment. Nursing staff had the most frequent and regular contact with patients and were often a link to the other team members. Discussion with patients however was typically limited to communication regarding basic care needs. As nurses did not exercise their role as a counsellor, but rather focused on the immediate basic needs, this is inconsistent with existing literature which states that nurses play a key role in counselling and assisting patients to lose weight and in caring for patients who are obese or have obesity related health problems

(Poon & Tarrant, 2009). Browne and Thompson (2007) also emphasized in their study that good communication tactics are important to establishing rapport with obese patients and with managing the sensitivity associated with obesity. The participants reported varying degrees of effectiveness of the nursing staff which subsequently impacted their perception of the hospital experience. Many participants stated not wanting to bother the nurses as they knew they were busy; however as described by some of the participants, inattention on the part of health care providers could lead to negative consequences and result in such things as not getting needed pain management, falling, or being discharged too early.

Communication from the medical team, both staff physicians and residents; received mixed reviews from the participants. Large groups of medical team staff were intimidating and many participants stated that their questions were left unanswered. The staff always seemed to be in a hurry and tended to talk about the patient but not to or with them. Some participants demanded to speak to the primary physician; others did not want to bother them because the doctor was busy. One participant spoke of getting answers when information was provided one on one and the physician took time to explain the answers. Limited interaction with physicians interfered with good communication and left many of the patients with limited understanding of their treatment plan. Similar findings were documented by Pulvers et al., (2009) which stated that good communication is critical when counselling patients about their weight.

Therapy can be both physical and psychological in nature. The majority of participants in this study received physical therapy, with only one participant received psychological therapy. Although surprising, the lack of involvement of a dietitian

reported by participants is supported by the literature (Campbell & Crawford, 2000). Dieticians, the discipline that may be of the most benefit to the bariatric patient (Huang et al., 2004), are often not involved in treatment especially during an admission to acute care, as obesity is chronic and not acute in nature. The intensity and frequency of the physical therapy varied depending on the participants' diagnosis and tolerance; for some individuals it was one or two visits to maximize mobility while others received daily treatments. Not all participants received therapy and subsequently limited information was provided on the care received. The participants whom did receive physical therapy however did feel that the therapists listened to their concerns and despite being busy had time to accommodate individuals' needs and limitations. Despite a paucity of research in this field, the findings of this study align with those of previous researchers (e.g., Sack et al., 2009).

Overall, whether it was nursing staff, a physician or a therapist the participants reported interaction time was limited so only the basic task was completed and minimal amount of information was provided. There was seldom time to establish rapport, just time to get the job done. Generally it was felt that high patient volume and job demands limited a holistic approach to care and resulted in receipt of only the essentials. The participants did not communicate receiving less care or being disrespected because of their size, they just accepted that the approach was the same with all patients and that is was a component of health care in general.

It is also evident from the data that the built environment challenged and limited the lives of the participants; however, many individuals seemingly accepted things as they were and made the best of their situations. They did not feel discriminated against; they

just felt this was how the system worked, regardless of age, body type or illness. The data indicated that for many of the participants' aspects of the built environment limited engagement in the daily activities of life. This is consistent with the research on the general population that states our physical environment affects our physical and mental health (Jackson, 2003). The built environment needs to promote activity and social interaction not the use of vehicles (Jackson, 2003). The built environment was a challenge to all the participants, with some being able to overcome the challenges through modifications and accommodations while others were more of a prisoner to the physical world. Throughout the interviews it was evident that the environment, both at home and in hospital, impacted functionality. The impact on functionality and withdrawal from participation in exercise and recreation outside the home due to bodily shame was referenced by Carryer (2001). For persons who are obese a properly designed environment can play a major role in enabling an individual to be able to care for one's self. From the narratives, the challenges of the environment included limited size, accessibility and options. Research shows that housing neighbourhood characteristics and transportation are the main environmental factors associated with health (Srinivasan, O'Fallon & Dearry, 2003). These concerns were also reported in the current study such as accessing stairs to access their homes. Many of the participants were also unemployed which impacts overall health as stated by Srinivasan et al. (2003), who reported the burden of illness is greater in low income communities.

In addition to the environment or physical space, the objects in the built environment also had a major impact on enablement. Generally speaking the beds were a topic of discussion for most of the participants, including issues of noise, heat, height and

“being a trap.” Bedside seating and transportation options (wheelchairs, stretchers) for receiving tests were also an issue discussed by many. It was felt, to a certain extent that the issues with the bed impacted rest and the ability to do for oneself. While in hospital, excessive time in bed is always discouraged as there is an increased risk of medical complications with inactivity including blood clots, pneumonia and bed sores (Bianchetti, Zanetti, Rozzini & Trabucchi, 1993; Pokorny, 2008). Patients are therefore encouraged to move around, sit up in a chair and change position frequently to minimize the onset of additional problems. The provision of adequate seating is important to maximizing time out of bed. Chairs must be of appropriate size and comfort for an unwell person to tolerate sitting and being out of bed.

Dignity during hospitalization was a consistent issue among participants. Without adequate equipment and space, patient dignity is impacted. Dignity is about being able to understand the patient as a person, not just a case, and help meet their needs (Stabell & Naden, 2006). Dignity, according to Henderson et al. (2009) is influenced through two mediums: communication style and physical environment. In the current study, dignity was especially an issue with respect to toileting; using the bed pan, using a commode that was significantly small or significantly large and needing assistance for hygiene was shared by many. This is congruent with the literature that states patients often feel their privacy is not protected, as curtains are not always drawn during transfers to chairs or commodes, skin is not always covered when walking to the bathroom and excess time is spent sitting on bedpans (Henderson et al., 2009). Although participants did not universally declare ‘dissatisfaction’ with hospital communication and care, analysis of the narratives indicated that they were aware that their experiences were less than ideal. As

reported by others (Henderson et al., 2009), participants seemed to accept the situation but at a minimum they expected to be valued and respected as a person.

3.4.2 Conclusion

A growing number of people with obesity suggest that health care environments and staff must adapt to meet the demand. Even though most of the study participants spoke positively (overall) about their admission there were barriers discussed by all. Poor communication, limited assistance, lack of information regarding medical status, quick and uninformative visits from doctors, nurses and allied health were most often described. The interviews also revealed that the environment and objects within the environment impacted physical function, ability to care for oneself and the subsequently the ability to get well and return to one's own home environment. The participants also described the small size of the rooms, lack of appropriate chairs, the beds being uncomfortable and the commodes being unsuitable. Many participants were aware of their large size and how providing care for them may be more difficult because of this. Some also spoke of leaving their dignity at the door upon being admitting to the hospital, noting that the lack of privacy, space and appropriate equipment further complicated the admission and the overall experience. In conclusion, the environment played a role in the overall perceptions of hospitalization. It was also evident that the home environment had impact on physical function. Most of the narratives revealed that physical space and equipment can either enhance or serve as obstacles to health and function.

3.4.3 Limitations

Even though saturation was determined to have been reached, the sample size was limited. Although gender differences were not overtly obvious there were only three males versus six females that participated which may have impacted obtaining a true construction of the hospital experience from the different genders. Only one subject resided in a rural area, so the impact of the wheelchairs environment in rural versus urban living situations may have presented itself differently with more participants from rural areas. The participants studied were primarily mobile and able to engage in self-care and productivity tasks. Most shared stories of reasonable hospital experiences with little to no thoughts of discrimination and stigma. This is in contrast to most of the literature reviewed for this study which stated that patients with obesity do not get the attention they need and are blamed for their health condition(s). Between group differences, that is stigma and discrimination based on their size in comparison to patients of healthy weight was not an issue for these participants.

Body type is often a sensitive topic, in particular amongst people who are obese as they are often marginalized. This concept may have influenced data shared as the primary researcher had a BMI of twenty versus the participants who had BMI's equal to or greater than forty. Reflexivity was used in an attempt to minimize the impact of this difference, as differences in appearance and physical difference may affect encounters as there is an apparent privilege associated with being of a gendered size norm (Rice, 2009). The goal was not to provide an extensive depiction of the perception of hospitalization of the persons with obesity but to understand concepts related to the experience. Age,

socioeconomic status, living situation and previous hospital experience of the participants may have impacted responses.

Analysis was also limited as only one interview was conducted with the participants. Additional interviews may have provided more details regarding the hospital experience as well as in establishing rapport with participants. Also most participants were interviewed within one to two months of discharge from the hospital. Perceptions may have been different if shared after an extended period following discharge. Finally, participants may have shared more details on this sensitive topic if a greater opportunity to establish rapport occurred which would be possible if more than one interview was conducted.

3.4.4 Recommendations for Future Research

As an emerging area of research, limitations in understanding obesity, its cause and its treatment exist. There are areas that are understudied, topics that are just surfacing for study and areas that are not well understood. There is a failure to recognize that obesity is a chronic illness (Wagner et al., 2001), that gender discrepancies exist and physician expectations are unrealistic (Dutton et al., 2010). Wagner et al. (2001) focused on the development of a chronic care model and in doing so discussed a variety of gaps that exist in the current system of care. During hospitalization the acute problem not the underlying cause or chronic condition is treated (Hamdy, 2010). A continuous healing relationship with follow-up and planning and coordination of multiple caregivers is not the current reality. A chronic care model needs to be developed for the proper management of obesity (Wagner et al., 2001). “Fitting in” to the current acute care model

is not the answer. In this study, the focus was on hospital experience however; further research in acute, clinic, outpatient and primary care is also recommended. Although the participants in the current study did meet the criteria for morbidly obese, it is proposed that the subjects in the literature had much higher BMI's, were not capable of doing for themselves and required much more direct care from health professionals. Finally there is the need to further explore physician expectations and attitudes toward people with obesity. Dutton et al. (2010) for example showed that physicians agreed that both males and females in their study needed to lose weight but the expectations were much higher for the female population. The expectations were often unrealistic resulting in failure and subsequently continued poor health. Future studies need to include a larger sample size, use a mixed methods approach, interview subjects more than once, compare perceptions between patients and care providers and include a greater range of BMI's, admitting health conditions, and socio-demographics.

3.4.5 Recommendations for Future Practice

Research in these areas and many others is needed to address the relationship between bias and accommodation that can impact on clinical practice; i.e. the failure to provide seating, beds, instruments and diagnostic equipment that accommodate larger people so their health issues can be properly assessed (Camden, Brannan & Davis, 2008). Facilities also need to provide adequate space to accommodate equipment and patient need. The narratives provided by the participants in this study suggest that caring for persons with obesity is complex and involves multiple health providers in different settings (i.e. emergency room, critical care). The built environment needs to increase

accessibility and accommodate individuals with obesity to allow them to participate in society and to engage in interpersonal relationships. In conclusion the current study aimed to explore the experiences of hospitalization from the patient's point of view, in particular people with morbid obese who were defined as having a BMI of greater than 40. Studies exist regarding the attitudes and challenges of health professionals' working with this population. To my knowledge, however, this is the first study to explore the perceptions of care and stigma from the perspective of the patient. By communicating with the patient and providing a caring environment strategies for best practice may be established and non-stigmatized, equal care for all can be provided.

CHAPTER 4: LEISURE PURSUITS OF PERSONS WITH OBESITY

4.1 Introduction

The rising prevalence of obesity has led to it being identified as a major, potentially preventable cause of premature morbidity and mortality (Peeters et al., 2003). The associated health risks include premature mortality, sleep apnea, diabetes and cardiovascular disease (Peeters et al., 2003). The causes of obesity are multi-factorial; genetic, behavioural, environmental and physiological (Sack, Radler, Mairella, Touger-Decker & Khan, 2009; Spence-Jones, 2003). Despite the prevalence, risk of co-morbidities and cost of health care increases, obesity is seldom addressed in the hospital system (Hamdy, 2010).

Patients with morbid obesity often come to the hospital for treatment of their co-morbidities rather than the obesity itself. Once presenting problems are addressed, the patient is often discharged without counselling or support regarding lifestyle changes (Thuan & Avignon, 2005; Al-Ghawi & Uauy, 2007). The emphasis is on medical management of a problem when a holistic approach to physiological, psychological, environmental and societal concern is needed. A holistic approach includes investment in valued life activities which are important to life satisfaction; loss of participation can have a negative impact on overall quality of life (Mannell & Kleiber, 1997). Once discharged from hospital, people return to their normal routine; using the ever increasing types of technology and participating in more and more sedentary tasks (Jallinoja et al., 2007). In addition persons with obesity experience anti-obesity bias; stigma from employers, the

general public and health care professionals (Puhl & Heuer, 2009; Puhl & Heuer, 2010) and a reduced quality of life (Hilber, Rief & Braehlar, 2008).

Obesity itself has not been well studied until recently and the focus has been primarily on the medical and health risks associated with being overweight (Wray & Deery, 2008). To take a more holistic view of quality of life, beyond that of health, leisure and activity participation among persons with obesity needs to be explored. In exploring the leisure pursuits of the individuals who are morbidly obese it may be possible to identify ways of increasing activity pursuits and encouraging unobligated time to be engaged in meaningful and satisfying ways.

4.2 Understanding Leisure and Obesity

It is through participation in valued life activities that life purpose and quality of life are established in connecting with others and acquiring skills and competencies. Leisure is important to overall quality of life (Wendel-Vos, Schuit, Tijhuis & Kromhout, 2004; Dishman, 2003) and it has been suggested that leisure has more of an impact on quality of life than any other area of behaviour and experience (Mannell & Kleiber, 1997). In general leisure yields more positive than negative moods and the experience is pleasant in both anticipation and recollection (Mannell & Kleiber, 1997). Leisure in life is also important as perceived freedom of choice and intrinsic motivation are central dimensions in people's lives.

The leisure lifestyle of a variety of groups with or at risk for chronic health issues has been studied in the leisure field (e.g., Li et al, 2010; Rosqvist et al., 2009; Son & Yarnal, 2011; Vanner, Block, Christodoulou, Horowitz & Krupp, 2008) as well as the

role of leisure in the prevention, self-management, and amelioration of chronic illnesses. Little attention has been paid to the leisure pursuits of the people who are obese. Within leisure studies, only two studies have been conducted on leisure and obesity (Dattilo, Dattilo, Samdahl & Kleiber, 1994; Lewis & Van Puymboreck, 2008). Dattilo et al. (1994) conducted a study on the leisure orientations of low-income, overweight African American women who were not employed outside the home. A questionnaire was administered to a convenience sample ($n = 222$) with a response rate of 82% which included a self-esteem scale, a leisure orientation scale and questions about body weight, body image and income. There were also two open ended statements included on the questionnaire about activity participation and constraints. The theoretical orientation of the study was not necessarily focused on obesity but was based on examining differences between men's and women's lives in terms of willingness to define women's household activities as work. Constraints to leisure identified in the study included household obligations, finances, lack of time for participating in leisure activities. Dattilo et al. (1994) also discussed decreased self-esteem and self-concept impacting leisure experience and a reduced ability to cope with stressful life event. Leisure provides opportunities that foster various forms of psychological well-being. It can act as a buffer to stressful life events, due to the positive feelings it evokes (Dattilo et al., 1994). Lewis and Van Puymbroeck (2008) also looked at leisure amongst persons who were obese and how stigma can be a significant constraint. The authors described how general feelings of disapproval in many facets of life negatively impact social interaction, resulting in negative leisure experiences promoting withdrawal from normal activity (Lewis & Van Puymbroeck, 2008).

There are a large number of benefits of exercise as a form of leisure: enhanced cognitive function; decreased risk of heart disease, diabetes and various forms of cancer; and helpful in reducing pain and decreased function associated with illnesses (Roshanaei-Moghaddam, Katon & Russo, 2009). Due to the importance of exercise in assisting in weight management and potential alleviation of co-morbidities associated with obesity (Chambliss, Finley & Blair, 2004), research on persons with obesity has primarily focused on the therapeutic value of activity (Bond et al., 2012; Cooper et al., 2000). According to Forhan et al. (2010) studies exist that explore participation in activity for the purpose of weight loss among individuals who are obese (i.e., exercise and physically activity leisure), but research on activity for the purpose of enjoyment is limited. Research on physical activity among obese persons has also focused on the personal (e.g., increased use technology, fewer active occupations, time and financial constraints) and environmental (e.g., increased use of cars) threats to an active lifestyle among persons who are obese (Puhl & Heuer, 2010). There is limited to no research on the leisure lifestyles of people who are obese.

Leisure consists of activities much broader than just physical activity pursuits, including arts, culture, outdoor esthetics and play (Henderson & Bialeschki, 2005; Thompson, Rehman, & Humbert, 2005) as well as social pursuits and engagements (Mannell & Kleiber, 1997). Leisure is characterized as specific types of activity (e.g., having coffee with a friend, going for a walk, knitting, playing tennis); as time which is free from obligations; as an experience which is satisfying and meaningful (e.g., intrinsically motivated, feelings of satisfaction, excitement, awe); or some combination of activity, time and experience (Kleiber, Walker & Mannell, 2011; Leitner & Leitner,

2012). Research states that recreational (or leisure) resources have important associations with health (Edwards, Jilcott, Floyd & Moore, 2011) which has been the primary focus of this topic among people with obesity. Leisure must be seen as a broad concept with the physical and mental benefits intertwined (Henderson & Bialeschki, 2005). Leisure has many benefits besides increased physical health including increased social, psychological and global well-being (Mannell & Kleiber, 1997; Crawford, Hollingsworth, Morgan & Gray, 2008). Exploring a broad range of leisure activities, holistic benefits and experiences of people with obesity is warranted.

4.3 Constraints to Activity among Persons with Obesity

Due to the narrow focus of research on physically active leisure pursuits and limited knowledge of the leisure experience among individuals who are obese, further research is needed including examining constraints to leisure participation in terms of both quantity and quality. There are many factors that can negatively impact engagement in leisure pursuits. Constraints are defined as anything that inhibits or reduces an individual's leisure participation or satisfaction (Jackson, 1988). These can be intrapersonal, interpersonal and structural; both experienced and anticipated by an individual (Jackson, 1988). Constraints to participation can include but are not restricted to finances, time management, changing interpersonal relationships, skills and physical ability. The ability to cope with personal, social and environmental challenges all impact ability and opportunity for leisure (Jackson, 1988). For people who are obese intrapersonal, environmental and interpersonal factors are particularly prevalent.

4.3.1 Intrapersonal Constraints as Determinants to Participation in Leisure

Intrapersonal determinants to activity participation and leisure include personal and psychological factors. Personal factors such as age, education level, severity of obesity and presence of weight related co-morbidities influence activity participation (Liechty, Freeman & Zabriskie, 2006). Psychological factors such as low self-esteem, low motivation, depression, and anxiety can act as constraints to activity and leisure participation among the general population as well as among the people with obesity (Dierk et al., 2006). Low self-esteem results in acceptance of situation and minimal desire/motivation to change (Liechty et al., 2006); low motivation reduces effort to participate. Social physique anxiety, a subtype of social anxiety, response to other people's evaluation of one's appearance, is more common among people who are obese (Liecht et al., 2006); the experience of social physique anxiety can limit leisure pursuits.

Depression and negative affect often reduces one's participation in valued life activities (Williamson & Schulz, 1992). Individuals who are obese may be more at risk for depression compared to the general population (Pazzagli et al., 2013; Xu, Anderson & Lurie-Beck, 2011). Dierk et al. (2006) reported that there is a significant positive correlation between BMI and negative affect. Other research suggests no difference in the prevalence of psychosocial constraints among the general and obese populations; as Carr and Freidman (2005) report data from clinical and community samples indicated that neither being obese nor overweight is associated with high levels of depression, anxiety or poor self-esteem. However, these population comparisons were with individuals who were overweight or obese and not with people with morbid obesity. Thus the experience and prevalence of psychosocial constraints (i.e. depression, low self-esteem) for those

with morbid obesity are not well known (Carr & Freidman, 2005). Theoretically, with improved psychological well-being there are fewer limits to behaviour and people are more likely to seek leisure participation (Kleiber, Walker & Mannell, 2011). This is true for any population but is particularly true for people who are obese as stigmatization often increases difficulties in social situations (Dierk et al., 2006).

4.3.2 Environmental Constraints as Determinants to Participation in Leisure

Environmental aspects to participation in leisure (and physical activity) for the general population and individuals with obesity includes accessibility and opportunity. The environment is designed around the vehicle and labour saving technology; subsequently lives are less active. Lack of accessibility to leisure spaces and facilities can act as a constraint to leisure participation (Crawford & Godbey, 1987; Francken & Van Raij, 1981). Use of recreation spaces can be limited if they are not accessible, either because of distance to the facility and/or aspects of the built environment (such as stairs).

Social demographics and geographic location can also act as constraints to leisure participation. Studies show there is a higher probability of being inactive in disadvantaged versus advantaged areas among all types of populations. In disadvantaged neighbourhoods it is less likely that facilities will be built and existing facilities may fall into disrepair, limiting spatial access to those of a lower socioeconomic class (van Lenthe et al., 2005). Self-report studies indicate that weight based employment discrimination is common among people who are obese (i.e. not being hired, being denied a promotion or fired) (Puhl & Heuer, 2009) thereby placing them in a lower socioeconomic class and subsequently in a more disadvantaged environment. Financial constraints can impact

leisure participation (Alexandris & Carroll, 1997; Crawford & Godbey, 1987). For example, van Lenthe, Brug and Mackenbach (2005) reported an inverse association between the objectively measured distance to pay facilities for exercise and self-reported exercise. Proximity to and financial means are associated with participation in physical activity and leisure pursuits (van Lenthe et al., 2005), both of which may be inadequate among people with obesity.

4.3.3 Interpersonal and Societal Constraints and Determinants to Participation in Leisure

Interpersonal and societal constraints such as increased use of technology, social stigma, and obesity stigma can act as constraints to activity and leisure participation. Increases in use of technology and media influence are societal factors that impact on the pursuit and type of leisure participated in today. Sedentary entertainment competes for time with leisure pursuits performed with others and outside the home. The use of computers and other technology such as cell phones has reduced the need for face to face encounters and activities as people use social media to engage with friends and acquaintances. Social media technology may be highly used among people who are obese to reduce experiencing social stigma or discrimination, thus limiting out-of-home participation.

Social stigma experienced by people who are obese acts as a constraint to activities within all areas of life (Puhl & Heuer, 2007). According to Chambliss et al. (2003), obesity is considered the last acceptable form of prejudice and discrimination against individuals and is prevalent throughout society. Obesity prejudice is associated

with negative character assessments such as laziness, lack of self-discipline and incompetence. Reduced friendliness toward people, who are obese, particularly in public places, is also associated with this stigma (Carels & Musher-Eizenman, 2010; Miller & Miller, 2010). Many obese individuals subsequently avoid the public places in order to minimize the psychological stress associated with public pressures of maintaining an acceptable body image (Carels & Musher-Eizenman, 2010). Being overweight or obese can restrict or limit people's engagement in occupations, their participation in society, their activity and social participation, and their overall well-being (Pizzi, 2013). Society subsequently acts as a constraint to participation in leisure pursuits among people with morbid obesity.

Obesity-stigma itself is a significant leisure constraint; which is a population specific constraint. Lewis and Van Puymboreck's (2008) study found that stigma associated with obesity is damaging to both social and psychological well-being. Individuals with obesity are more vulnerable to discrimination than other marginalized groups; with discrimination promoting withdrawal from normal activity and impeding social interaction with others (Lewis & Van Puymboreck, 2008). Support may also be limited for someone with obesity due to stigma by association. Discrimination can result in average weight individuals distancing themselves from obese individuals so as to not have the negative attributes applied to their own self. Without supports, engaging in leisure pursuits is less inviting, response to social endeavours and health treatment or behavioural change are less-likely (Lewis & Van Puymboreck, 2008). Social support can either impede or facilitate leisure participation (Mannell & Kleiber, 1997).

Caloric imbalance is a simple response to a complex problem; just as exercising as a physical activity limits the spectrum of the term leisure. Personal, environmental and societal constraints including finances, access, support, and social stigma are all relevant factors in exploring the leisure pursuits of the morbidly obese population. The aim of this qualitative study was to explore the hospital experience of persons with morbid obesity in an urban centre in Atlantic Canada. During the discourse participants described their participation and experience in leisure which is the focus of this paper.

4.4 Methods

4.4.1 Research Design

An interpretive approach was used to understand the world from the point of view of the participants. In using phenomenology, the complex meanings of participants' social reality can be captured (Green & Thorogood, 2009). This approach focuses on lived experiences and the meanings, interpretations and interactions associated with those experiences (Dionigi et al., 2011; Hesse-Biber & Leavy, 2004). This study utilized a qualitative research design. In-depth semi-structured interviews allowed for examining the subjective and lived experiences of participants in order to explore reasons for behaviours, beliefs, conditions and events. The role of the researcher was to elicit stories of personal experience. Protocols for the study were reviewed and approved by the university and hospital ethics committees. The primary investigator was both athletic and a health professional (occupational therapist). To protect against potential stakeholder bias, strategies including coding and evaluation of themes by other researchers was utilized (Green & Thorogood, 2009). Memo writing was also used to examine personal

biases (Punch, 2000). Member checking was also offered to participants; however no participants wanted to review their interviews once transcribed.

4.4.2 Participants

Participants in this study included adults (19 years of age and older) who were inpatients at one of two acute care hospitals (pseudonyms Riverside and West End Hospitals) in a major urban centre in Newfoundland, Canada. Participants were included if they were morbidly obese (Class III), which is defined as having a body mass index (BMI) greater than or equal to 40 (Statistics Canada, 2013; Lewis, Thomas, Blood, Hyde, Castle & Komesaroff, 2010). Study information was circulated to health care providers within the institutions who identified and made initial contact with potential participants. Participants were recruited using purposeful sampling techniques. Health providers within the participants 'circle of care' were asked to identify potential participants in one of two ways 1) through the health record, which contained documentation regarding weight and/or BMI or 2) visually, based on anthropometrics. For participants identified visually, after obtaining consent, weight and height measurements were obtained and BMI calculated to determine if criteria were met. Following obtaining consent in the hospital setting, the interview scheduled at a time and location of their choosing. Sample size was not predetermined. Data was collected to the point of saturation (Greene & Thorogood, 2009), that is, until no new data was generated (sample of nine participants). Table 2 describes the participants using pseudonyms to protect anonymity.

Table 2: Characteristics of Participants

1	Marjorie; 70 year old female; lives with son and 2 grandchildren; unemployed; does not drive; enjoys bingo; leisure limited by arthritis; enjoys bingo.
2	Darren; 36 year old male; lives with wife; employed but currently off work on disability; driving and leisure limited by rheumatoid arthritis; smoker; owns a treadmill; enjoys walking his dogs.
3	Lisa; 55 year old female; lives with husband; employed as daycare worker; has driver's license, has not driven for an extended period of time; spoke of her job as leisure – enjoyed her occupation.
4	Susie; 59 year old female; lives with husband; unemployed; does not drive (nor does husband); enjoys playing cards; does not participate in active leisure pursuits due to shortness of breath; smoker.
5	Clayton; 70 year old male; lives with wife; retired health professional; drives; enjoys spending time on the computer.
6	Debbie; 54 year old female; lives alone; retired from one job, employed in another; drives; enjoyed time with family and going for coffee.
7	Betty; 61 year old female; lives alone; unemployed; does not drive; enjoys time on the computer; housebound due to high oxygen requirements and inaccessible housing.
8	Beulah; 56 year old female; lives with friend/care-giver (who drives); unemployed; enjoys making jewelry and spending time with her cats.
9	Walter; 65 year old male; lives in personal care home; retired civil servant; not able to drive due to current medical issue; enjoys time on the computer.

4.4.3 Semi-Structured Interviews

To elicit personal stories and narratives, the current inquiry conducted in-depth, face-to-face, semi-structured interviews. Detailed field notes and memoing of participants' environments, gestures and emotions helped to enrich the data collected. The initial broad interview guiding questions (Table 3) were developed based on investigator consensus and literature review as well the primary author's own experiences working within a health care institution.

Table 3: Broad Interview Questions

Obesity Experience: What are some things you enjoy doing? Tell me some activities that you would like to participate in but are not able to. What are the reasons that you are not able to participate in activities that you enjoy?
Typical Day: Explain a typical day. What do you do from the time you get up until the time you go to bed?
Social Activities: What types of activities do you participate in outside your home? Do you do these for enjoyment or if they are chores or work related tasks.
Family/Friend Relationships: How are your family and friends supportive of your routine?

These open-ended guiding questions were expanded upon using more focused individual response-specific probes (e.g., how did that make you feel?) as needed both during and between participant interview sessions. Guiding questions permitted further exploration and understanding of the participants' thoughts, beliefs, attitudes and experiences related to participating in leisure pursuits (Thompson et al., 2005). Following each interview, the guide was reviewed and adapted to address new themes that presented themselves from the data collection and analysis. Careful consideration was given to the language used, due to the sensitive nature of the topics discussed (Green & Thorogood, 2009). Although questions were designed to encourage participants to reflect on their experiences during hospitalization, participants were asked to discuss everyday life and challenges associated with having obesity (e.g. dressing self, access and engagement in social activity).

Data was collected, between February and August 2012, following discharge from the hospital as this allowed the interview to be conducted in an environment deemed comfortable and safe by the participant; privacy can be a challenge in an acute care

setting. Participants were interviewed once in a location of their choosing, which for all was in the comfort of their own home. According to Manderson, Bennett and Andajan-Sutjaho (2006), the home invites the interviewer into the interviewees' private life, shifting the balance of power and providing context. Interviews were 60 to 90 minutes in duration. The primary researcher conducted the interviews which were audio recorded. Participants provided oral and written consent. Participants were given the opportunity to review their transcripts; they all declined.

4.4.4 Data Analysis

Since, the primary goal of this study was to understand the social reality from the viewpoint of the participants employed, thematic content analysis was used which is a flexible method commonly used in health-related research (Green & Thorogood, 2009). Understanding the participants' words and narratives they shared guided the data analysis. Analysis began following each interview with interviewer reflection and supplementary note taking (Neuman, 2007) which recorded non-verbal communication, rapport and environmental observations. Supplementary reflective notes were integrated into the interview text (Punch, 2000). Interviews were transcribed immediately following each interview so as to maintain accuracy of the story told (Green & Thorogood, 2009). Immediate transcription allowed for exploration of emerging issues and investigation of under-represented ideas by modifying or retargeting questions prior to the next interview. Iterative open coding techniques were used to identify key concepts as they emerged from successive interviews (Punch, 2000). Following the first four interviews, a coding scheme was created which grouped the open codes into themes that gave meaning to the

data (Green & Thorogood, 2009; Neuman, 2007; Punch, 2000). The coding scheme was modified, codes moved or relabeled as new themes emerged in subsequent interviews. Throughout the analysis process, theme characteristics were described and refined. Representative participant quotes were also identified with note taking and highlighting of interesting comments (Green & Thorogood, 2009; Punch, 2000).

Following transcription and coding of all nine interviews, all transcripts were read and re-read several times to increase familiarity with the data collected and to ensure that the final coding scheme represented the entire content of the interviews (Green & Thorogood, 2009). A second researcher, who did not participate in the interviews, read three representative transcripts, identified codes and determined alignment with the final coding scheme; no modifications to the initial coding scheme were required. The coding scheme main themes were subdivided into subthemes with examples and quotes applied to each subtheme category (Green & Thorogood, 2009; Punch, 2000).

4.5 Results

As part of the exploration of their hospital experiences, participants were asked to describe their typical routines and activities. They reported that these routines were temporarily interrupted during recovery from hospitalization resulting in most participants strongly depending on family and friend support for housework and related tasks (i.e., activities of daily living). Participants' described that their leisure pursuits did not significantly vary from pre to post hospitalization. They experienced barriers to participation in leisure such as environmental barriers and health issues, which may have reduced the sense of enjoyment and desire to participate. Six sub-themes were identified

within the theme of leisure, from the interviews of nine participants following discharge from acute hospitalization. First was the concept of solitary in-home sedentary leisure, second was social out of home sedentary leisure, then paid work as leisure, lamenting leisure losses and finally health and environmental leisure barriers.

4.5.1 Solitary In-home Sedentary Leisure

Most participants spoke of their leisure time as being primarily sedentary; watching television and surfing the Internet being common activities both before and following hospitalization. Darren explained he spent most of his time on the computer, *“especially in the winter as it is hard to get out.”* Betty stated *“I can’t really do exercise, if I goes from here to the bathroom I gets winded.”* During the day, *“I spend a lot of time watching cooking shows,”* while her home care worker, who is there daily from ten in the morning until four in the afternoon manages meals and the household chores. In addition to watching television, Betty spoke of waking at night and getting on her computer. *“If I gets on the computer probably 3:30 in the morning, and I am just playing games, I don’t know anything about face book and that stuff; I don’t know how to use the keyboard.”* She explained it helped to pass the time away as she is often alone at night. The computer was not just used for leisure (e.g., games) but also for personal and house-related tasks. Darren used the computer to research his medical conditions and medications. This was something he did often as the activity did not bother him physically or cause joint pain or flare-ups like most physical activity did. Walter used the computer for banking and other related tasks. Playing cards was something that Susie enjoyed. Many individuals enjoy the social aspect of cards and the opportunity to spend

time with friends; however, for Susie the game took place within the comfort of her own home, which was evident with the half completed game of cribbage on the coffee table; emphasizing engagement in sedentary activity and participation within the comfort of home. Other sedentary leisure pursuits enjoyed by the participants included smoking; for Susie walking to her patio was an accomplishment where she enjoyed a smoke, which she did not intend to “*give up.*” Darren also spoke of smoking as a leisure pursuit; how it brought him pleasure and allowed him to fit in with the crowd despite his arthritis; it was something he “*was good at.*”

The participants spoke about their leisure pursuits as occurring mostly indoors, primarily within the safety and security of their own homes. The leisure pursuits were typically non-active in nature and performed in isolation. For example, Beulah was a fan of television and enjoyed cooking shows; an indoor, sedentary activity. One of Marjorie’s preferred leisure pursuits was also watching television. She explained that in hospital she was initially very unwell, and she “*missed a few days,*” of her favourite program. As she improved her family transported her (by wheelchair) to the family room (in the hospital) to watch “*her*” show, but she felt disappointed that she had missed too many episodes to follow the storyline, explaining, “*I looked at it, but I don’t know what it was about.*” This indicates that when unwell, even activities that are typically enjoyable can be unpleasant. Other than using the computer, Clayton for example never spoke of leisure pursuits. He focused on his hospital admission and on caring for his wife who was unwell at home. From his description it seems he was a hard working individual who had owned his own business and who placed pride in providing a service to his clients. His wife also had a busy career so there was seldom time for leisure. Now with recovery

from his current knee surgery, and his previous knee surgery (one year prior) leisure was not something he pursued. Additionally, with his wife being unwell he dedicated his time to providing for her. He spoke of being a “*very private individual*” and not wanting to go to one of those homes where he would be forced to socialize. “*I don’t feel the need to necessarily play Bingo and that kind of stuff and I don’t want to be rude to people either to tell them what to do with their bingo (laughter).*”

Participants did speak of positive in-home leisure experiences. For example, when Beulah was asked about her pursuits inside and outside the home she spoke of making jewelry and shopping. Beulah had intended for her interest in jewelry making to become a business, but without money to invest, her interest has become her hobby.

I make jewelry for really little girls, that like to have their bling and mom only wants to spend five dollars and doesn’t care if it gets lost or anything and I make jewelry that you would pass onto your daughter.....

In her room there was a desk area with various stones, beads and wires. She also spoke of wanting to take a course in jewelry making but not having the money to be able to do so. In addition to her hobby, she spoke highly of the two cats, “*family cats.*” They were a distraction and good company. They enjoyed spending time with Beulah in her room, which had a large window to the back yard.

The concept of leisure is vast, encompassing a variety of different activities, with the overall principle being the achievement of enjoyment. Results to this point have referred primarily to more sedentary tasks. One participant however, Darren, engaged in ‘physically active’ leisure pursuits. Although his participation was not consistent he talked about walking his dogs and using his treadmill:

I am trying to get going on the treadmill and this is the stuff I have never done, so even without a heart attack, trying to ramp up, my knee has always been bad, so the problem is say over ten years my weight gain has been gradual, ten to fifteen pounds per year, and then you know you wake up one year and you are like wow.

4.5.2 Social Out-of-Home Sedentary Leisure

Participants described feeling restricted in leisure outside the home. Their out of home activity primarily focused on essential tasks. Several of the participants however valued the social connection offered through leisure activities outside the home. For example, although Marjorie was now somewhat housebound while recovering from her pneumonia and upper respiratory tract infection she also described routinely going to Bingo on Wednesday nights before becoming ill. Her grandson would drive her to bingo whenever she wanted. For Marjorie, this leisure pursuit offered dual enjoyment; spending time with her grandson during the drive and then with friends during the outing. When asked about returning to this activity when feeling better she stated “*oh, I will go back to Bingo.*” Unlike watching television, Bingo takes place outside the home and involves socialization with others, but it remains an indoor activity.

In addition to accessibility issues, breathing problems and joint pain participants described limited ability to participate in dynamic tasks. They felt no energy or motivation for active leisure. For example, Beulah discussed the joy of her new home as it had a ramp and she could easily get outside if she wanted to, but she never went out much anymore. “*I don't go anymore to the supermarket, I don't go to the drugstore but we have doctor's appointments.*” She explained that it “*gets to be a painful experience....Everytime I have to slide in and out of the car I would hurt my stomach right here (holding the front lower part).*” For Beulah it just became easier and more

comfortable to stay at home. She would go out only for appointments and not for leisure. She described how she hoped she would get thinner so that she could start going out again rather than being stuck at home. This was in contrast to Clayton who spoke of the enjoyment of his own home. He enjoyed the comfort of his own home where he was free to move about from one floor to the other (2-storey with an elevator) and go on the computer when he was not able to sleep. Having the freedom to do as he pleased at home prompted feelings of contentment.

Walter's talk of leisure pursuits was equally as limited as Clayton and Debbie's. Walter spoke of his time in hospital, his wife and his children. He had much to offer about hospitalization because of the length of his stay. He also faced much emotional stress as his wife was also unwell and admitted to a different hospital limiting options to visit. In general it appeared that most participants struggled with the day to day activities, leaving little time or energy for leisure. Similar to Clayton, Debbie did not refer to participation in leisure pursuits. She did however speak of time with her sisters as something she enjoyed; visiting and having a social cup of tea.

4.5.3 Work as Leisure

Leisure was experienced for some of the participants within their paid and unpaid-work activities; such leisure pursuits can result in durable and lasting benefits (Leitner & Leitner, 2012). These experiences occurred outside of the home; yet were still indoors. Three participants were employed (Lisa, Debbie and Darren), but at the time of the interviews were all off work due to their health and hospitalization. Lisa shared stories about her love of the children she cared for at the daycare, to the point that it was

comparable to a leisure pursuit for which she was lucky enough to be paid. *“Oh my goodness yes, yes I want to go back, I can’t wait to go back.”* She explained how the staff were supportive in her struggles at work before her surgery and how the children were always wondering when she was going to get her *“new legs.”* *“Oh be careful with Lisa, you almost hurt her legs that time [mimicking a co-worker].”* Lisa worked in daycare for twenty two years and she thoroughly enjoyed it, explaining that it gave her a *“quality of life and a sense of purpose.”*

Debbie described her job similar to Lisa. She had been employed for years with the government and had retired some time ago but was finding the day to be long without a purpose to her day. Upon retiring she took up a position with a not-for-profit group. *“The winter months were getting long, needed something to occupy my time.”* Although this was paid work, she found it thoroughly enjoyable as it involved helping others. It was very different from her previous employment and was something she enjoyed. She had only been involved with for *“three months before all this happened,”* referring to her diagnosis and surgery. She fully intended to return to her duties at work when she was recovered as it helped to pass the time and was meaningful to her. For these participants they were fortunate to be paid for something they thoroughly enjoyed and received pleasure from.

4.5.4 Lamenting Leisure Losses

Not all of the participants were able to have “pleasurable” work or have the ability to continue to participate in their preferred leisure activities. For most of the participants their activity levels had declined following their hospitalization. They spoke of the hopes

of gradually returning to their preadmission level of function as they started to get stronger and feel better. When asked about participating in activities outside the house only one of the interviewees, Susie, adamantly said “*absolutely not.*” When I explored this response a little further, she shared that back in high school she engaged in activity outside the home, but never talked about what the pursuits were. “*I am not active at all.*” Although her house appeared tidy, she spoke about her Christmas decorations just being poked in the closet and not even being in the boxes yet [Susie was interviewed in April]. Susie’s activity level however had not changed much: “*I have days when I can work so much that I gets out of breath, but they are few and far between.*” She explained she was happy to walk out onto her front deck and sit and have a smoke. She was content to do this, while her husband managed much of the household. Although apparently happy, Susie did share stories of the past.

I would love to be able to go walk, I would love to be able to do what I used to be able to do...me and mom...from here, to the store is five miles...me and mom now, ten years ago, now ten years is not a long time, we used to walk over there, get a Pepsi or whatever and walk back again, summer evenings.

My husband and I used to walk over there...and there is a big rock way up there . . . we would go and sit on the rock and throw rocks in the . . .

In sharing these stories, the enjoyment of the walks and time spent with family was evident in her voice. She explained that her breathing, her weight and arthritis just does not allow her to be ‘active’ anymore. She stated with laughter: “*I know what needs to be done; I am just too lazy to do it.*” Susie also explained being on antidepressants and how sometimes it is just hard to get going. “*Me and my sister in law, I thought the world of her, I mean she is in Ontario now, she has been for past ten or twelve years but she was*

my saviour, oh my dear she was so good, you know we would always be doing something or walking or active . . . Oh I was full of energy.”

Betty discussed her breathing requirements as impacting her ability to do things she enjoyed doing. She described getting short of breath just walking to the bathroom. *“I can’t really do exercise . . . if I went from here to my bathroom and back out again I am phewww (winded).* The emotional and psychological components of obesity were also shared by Darren and Clayton. Darren spoke of rough patches and inability to get into a routine, while Clayton enjoyed seclusion in the confines of his own room at the personal care home. Their challenges seemed to be rooted in limited physical function and low levels of motivation.

Having someone to exercise with to maintain physical health was also important for participants and they described how losses of exercise partners impacted their motivation. *“No, no, so me and Shirley would go for a bit of fun, my god we went there for 4 or 5 years together and I stayed down you know in weight a long time.”* Marjorie also mentioned going swimming with the girls in the past and how she should go again. She found having a group to go with to be motivating, but it was hard to self-motivate to be physically active with her health issues and being away from her group of friends.

Walter also spoke of losses. For him they were environmental and health in nature. Walter spoke of environmental barriers as he struggled with not being able to return to his own home and having to reside in a care home. He shared stories of working with the university and enjoyed helping students . . . *“I got around it, whatever way I could to help those kids get the careers they wanted.”* In addition to work providing him with fulfillment, his home *“around the bay”* [rural living] was evidently important to him

as well. He and his wife had moved around the bay following retirement to a quiet place with significant distance between homes. *“Around the bay, we had a neighbor way down there and another way down there.”* He enjoyed the tranquility and peace of open space and privacy. *“I am the type of person; if I had a choice I would be so far into the woods that I would have to come out to hunt . . . I want space.”* His preference for personal time was also evident in his choice to spend much of his time in his new residence in his own room, away from the other residents; he was on his computer in his room when I arrived for the interview. Part of this choice related to the age difference of Walter and the other residents but also his desire to just sit quiet. Walter never focused much on leisure pursuits as they had not been an important part of his life, his focus was now on just being able to walk and regain *“freedom.”* From the results it is evident that leisure can take on many forms and varies from one person to the next, but the key is the feeling of enjoyment and pleasure. Participants consistently described the eventual loss of physical activity due to the challenge of obesity and chronic health issues. They lamented their losses; thinking and hoping for the way things used to be.

4.5.5 Health and Environmental Leisure Barriers

Participants described how they intended and hoped to become more physically active but were stymied and discouraged by their medical conditions and obesity-related shortness of breath. Marjorie stated *“now I got lots of energy, but the reason why I don’t exercise is that hips are deteriorating with arthritis and they pain certain days and my knees.”*

For Darren challenges to his leisure pursuits included his excess weight, his recent heart attack and his rheumatoid arthritis. *“Tried using the equipment at home, but could not get past the knee pain, so some painkillers were implemented.”* Darren had difficulty with many of his joints and was currently off on disability from work. He struggled with getting into a routine and described things as being a *“long battle”* just trying to get into a routine and to keep busy. He realized that positive thinking was important to establishing this routine but that keeping optimistic was sometimes a struggle. *“Ahh, ahh, there are rough patches.”* He explained that he and his partner started doing some renovations, but he would suddenly not feel good and then not complete the job because he *“can’t be at it and he don’t want to be at it.”* He tried doing outdoor activities like walking his dogs but the terrain would bother the arthritis in his ankles. There was a sense of low mood in his narrative but he was realistic in saying:

my biggest goal right now is just to get moving, I don’t care about losing five or ten pounds a week or anything like that, I am seeing a dietitian and I am eating properly, I mean I know it is a long road.

His heart attack at age 36 had scared him and he knew something had to be done, but finding the motivation to do it was difficult. In addition to health barriers, environmental barriers challenged the ability to participate in leisure. Betty spoke of wanting to go out and go shopping, but in addition to her breathing problems there were multiple stairs to get in and out of her house. When asked about the last time she had been out of her house she responded with *“oh my god, I can’t remember, a couple of years. The only way I get out of my house is by the paramedics.”* She described a desire to lose weight so her breathing would improve and she would be able to get outside her home. *“That is why I*

want to lose weight so much . . . to get out . . . not saying I got it bad, but just to get out and to poke around.”

Similar challenges faced Beulah, but accessibility of the home was not the problem, mobility was. Beulah had a ramp to enter and exit her house, but due to her body type, relied heavily on a wheelchair and could walk only very short distances. So for Beulah it was not the problem of accessibility of her own home, it was lack of accessibility of public places that kept her from engaging in activities outside the home.

It is evident that the pursuit of leisure can be impacted by personal and environmental constraints. Also when unwell, the pursuit and enjoyment of leisure may be further reduced. For many of the participants, inactivity was associated with excess weight and there was minimal internal or even external motivation to stimulate participation in leisure pursuits, either of a physical or more intellectual nature. Lisa described being caught in a cycle of weight gain, health related-inactivity and further weight gain. Lisa had severe arthritis limited her walking ability which further impacted her weight:

then my mobility got worse; any exercise I was getting - shopping, supermarket, up and down stairs at work, whatever, that got so limited [because of knee pain] so then of course weight went on. At Christmas I went to the shop and I said there is no way I can walk around the store, so I got an electric chair.

Interestingly, Lisa acknowledged being overweight, but felt her joints themselves were the bigger issue impacting her physical health rather than obesity. Lisa described how fairly routine activities such as getting in and out of bed were impacted by her health “*I had to get my bed lowered on the floor cause it was too high...actually my bed was so high I had to get up on the step stool to get into it.*” This is both a physical health and

environment issue, but indicates the basic movement challenges that a larger person may face during routine tasks.

4.5.6 Summary

Within the theme of leisure, participants described activities ranging from the physical, emotional to the intellectual. The interview data revealed that despite being relatively young (aged 36 to 70 years) the participants' leisure pursuits became narrowed over time due to obesity and chronic health conditions. Some lamented the fact that they had lost many social and physical leisure outlets while others described adjusting and 'making do' with their current situations. When participants reflected on their past leisure activities of simply walking and going shopping, they described both acceptance "*now it is just the way it is,*" as well as an underlying desire to be able to do more. Losses of leisure were often associated with reduced socialization, loss of paid work, and frustration. Activity needed to be goal driven and for some that objective had been lost with the excess weight and associated illnesses and subsequent challenges to participation.

Most leisure activities took place within the home and were seldom physically active. Watching television, playing games on the computer and searching the web were common activities among participants. Some felt that they were caught in a cycle of reduced activity and weight gain but expressed hope for an improvement in their situation. It is evident that the participants in this study have the same exercise adherence issues as the general population but they also have the challenge of obesity and chronic

health issues along with the associated social stigma. These challenges are an added barrier to the individuals with obesity getting active.

4.6 Discussion

While examining the experiences of hospitalization among people with morbid obesity participants described their participation and experience in leisure. The concept of activity participation was discussed during the participant discourses from which a theme around leisure emerged. Six sub-themes were identified within the theme of leisure: solitary in-home sedentary leisure, second was social out of home sedentary leisure, paid work as leisure, lamenting leisure losses and finally health and environmental leisure barriers. Research has shown that negative attitudes toward obese individuals are pervasive in North American society (Puhl & Heuer, 2010). Obesity has been called the last acceptable form of prejudice and discrimination that is prevalent throughout society (Chambliss, Finley & Blair, 2004). Stereotypes of laziness, non-compliance and lack of will impose suffering on this already vulnerable group. This coupled with environmental barriers and increases in modern technology contribute to the sedentary lifestyle and engagement in non-active leisure pursuits. This was evident in the current study, with the number of participants who spoke of enjoying time on the computer. Multiple personal, social and environmental factors typically affect opportunity and ability to participate in leisure pursuits. The results from this study indicated that leisure for these participants generally involved sedentary tasks. Access and opportunity were important factors contributing to sedentary leisure pursuits. Friend

and family support to encourage activity were also prevalent influences to leisure participation.

As the data collected was part of a study that focused on perceptions of hospitalization, leisure pursuits were not an exhausted topic during the interviews. However, among this sample of morbidly obese acute care hospital patients, leisure primarily consisted of inactive, indoor activity. The current research findings are consistent with the literature that states that persons with obesity are characterized by high levels of sedentary behaviour and infrequent engagement in structured or moderate to vigorous physical activity (Bond et al., 2012). The findings are consistent with Dattilo et al. (1994) who found low-income, overweight African American women experienced low levels of leisure participation due to leisure constraints arising from multiple areas including low self-esteem, lack of social partners, imposing family obligations, or limitations due to time, money and access. In the current study participants spoke of experiencing several psychological, environmental and social constraints to leisure participation including poor health, psychological issues including lack of motivation, physical environment, cost and social support.

Obesity impairs walking ability and activities such as stair climbing, body transfers and other mobility related activity (Vincent et al., 2011). Walking impairments are significant as difficulty walking is an early indicator of chronic disability among obese individuals. Two out of nine of the participants in this study were wheelchair users. Overall poor health was a common constraint to activity participation among the participants. Activity levels were impacted not only by the recent hospitalization but also by co-morbidities. Baseline activity limitations were further impacted following discharge

from hospital. Physicians' recommendations to limit activity due to increased oxygen requirements, post-operative restrictions and/or due to generalized deconditioning from reduced activity during hospitalization contributed to prolonged periods of inactivity. With overall health limiting physical capacity, travel to, and participation in, an activity outside the home may not have been feasible for the individuals. Participants in the current study expressed concern about their excessive weight and how it impacted their daily lives, most however accepted their situations.

Reduced physical health is often associated with psychological changes including motivation, negative affect and decrease in pleasurable experiences (Mannell & Kleiber, 1997). Changes in overall health impact mental health including motivation to activity participation (Dattilo & Kleiber, 1993). Although participants in this study lamented leisure losses, most described feeling satisfied with their leisure pursuits. Pleasure from leisure was reduced among participants and some participants' spoke of experiencing negative moods and depressive symptoms. This is consistent with Dierk et al. (2006) who found depression to be more prevalent among persons with obesity. For those with depressive symptoms there is a higher prevalence of perceived barriers (Williamson & Schulz, 1992). Participants spoke of successful past attempts at being more physically active but that circumstances changed and perceived barriers to participation were high; friends moved, overall health further declined and priorities changed. Weight and overall poor health just didn't allow participants to be active anymore. The limitations of obesity on physical capacity resulted in increased time watching television and computer use among participants. Excess time per day doing these activities is a risk factor for being overweight and obese; thus resulting in a cycle of inactivity. Participants lamented the

loss of their preferred leisure activities. They believed it was too late to try things and too old to pursue enjoyment and they would just continue with their current lifestyle.

Acceptance of a new (reduced) level of ability and belief that being active was just not possible anymore were commonly spoken about during the interviews. If success in the behaviour was not anticipated then the activity was avoided suggesting that participants lacked leisure and activity efficacy expectations (Bandura 1986, 1997; Mannell & Loucks-Atkinson, 2005).

Lack of interest to participate in out-of-home leisure among participants may also be associated learned helplessness. Learned helplessness is the phenomenon in which experiencing repeated failures and uncontrollable events create passive behaviour toward succeeding threats to well-being often leading to development of depression and low self-esteem (Seligman, 1975). Multiple attempts at weight loss and failures at successfully participating in valued life activities can lead persons with obesity to experience frustration and hopelessness which can result in the development of learned helplessness (Collins & Bentz, 2009). In the current study, participants described multiple barriers to leisure participation and most expressed that they were content to live as they were currently living.

The physical environment was a large determinant for the participants with respect to the leisure pursuits in which they engaged. Stairs to enter and exit their homes and public buildings posed a physical challenge. Lack of ramps and/or elevators for wheelchair users or those with minimal walking tolerance influenced opportunity. Participants described that public places are often not friendly to persons with obesity in terms of chairs, bathroom facilities and entrance ways, and thus public settings were often

avoided by participants. Travel distance was another factor effecting leisure and activity participation, especially when the individual was unable to drive and there was a need to rely on others for transportation.

Social support was also a factor that appeared to influence leisure and activity participation among participants in this study. Many of the participants lived alone and lacked a strong social support network. This lack of social support appeared to impact participants' motivation to participate in pleasurable leisure experiences and their ability to participate in activities outside of the home. Those who did have family and friends to support them (e.g., Marjorie, whose grandson drove her to bingo and Betty who occasional did errands with her friend/live-in caregiver) spoke of the meaningfulness of being able to get out of their homes. Without friends and family this would not have been possible as neither one of them had their driver's license. According to Stahl et al. (2001) the strongest predictor of activity levels is the social environment; those who perceive low social support are twice as likely to be sedentary than those who have a high level of personal supports. Similar studies also showed the importance of the social environment; availability of friends may increase activity levels and be a general form of social support. For example, Rosqvist et al. (2009) found that those participants who had stronger levels of social support were more likely to participate in activities outside of the home and be more physically active. In the current study, Marjorie participated in bingo outside of the home with her grandson who helped her travel to and from the activity. Pets can also be a form of social support as evident by Darren who got out of the house to walk his dog. Thus, the importance of social support must be recognized in order to increase activity participation and quality of life among obese individuals. The aim is to empower and

promote public health through not only individual change but change within families and communities (Johnson & Perkin, 2008).

Whether due to environmental or psychological barriers, participants in this study spent the majority of their leisure time within their own home. Because of intrapersonal and environmental barriers, people are increasingly turning to the internet to meet important social and psychological needs (McKenna & Bargh, 1999). People have the inherent needs to feel a sense of belonging and relatedness and to have positive feelings about oneself including self-esteem and sense of self-worth (Deci & Ryan, 1991, 2000). Through the Internet, without exposure of one's physical self, these feelings can be achieved. This was evident in the current research in which several participants spoke of spending hours on the computer. Computers allow interaction, interfacing and pleasure without judgment or stigma. Access to the computer is within one's home - a "safe" environment from obesity stigma. Participants tended not to place themselves in situations in which they were not comfortable. Leisure time spent within the home and on the computer among persons with obesity in this study is in partial contrast to Dattilo et al.'s (2004) study who reported that low-income overweight woman had a preference for recreation that allows them to leave the home. Although the participants spoke of leisure pursuits within the home, some did share the desire to get outside. In the past Beulah would go out the car but now it is too much pressure and discomfort on her abdomen; Clayton who was able to drive also spoke of most vehicles being too small; and for Betty, stairs to enter and exit her home prevented her from getting out of "*her cage*." The intent of the study was to explore the experiences of the person's with morbid obesity during hospitalization in acute care facilities. Participants were asked questions regarding

their activities of daily living; however, questions asked did not fully explore the experiential nature of leisure experiences or reasons for level of interest or satisfaction. Time spent in these activities was not known and the examples of leisure activities discussed by participants likely reflected only a small number of lifestyle activities engaged in by participants. The six sub-themes resulting from this study (solitary in-home sedentary leisure, social out of home sedentary leisure, paid work as leisure, lamenting leisure losses and finally health and environmental leisure barriers) are not necessarily tied directly to obesity. Socio-economics, age, health issues which may or may not be related to or exasperated by obesity and other socio-cultural factors could also explain the leisure experiences of these individuals. Considering that obesity is closely related to all of these factors, due to the nature of questions asked (which focused more on hospitalization and activities of daily living) the data is limited in exploring how these themes are directly related to obesity. Further study is needed and it is recommended to explore the leisure lives of a sample that is more homogeneous in terms of socio-demographics and health issues.

Limitations of the study also include the sample selected who were participants recently discharged from an acute care hospital and were recovering from their admission. Subsequently activity participation was likely impacted by their current state of ill health. Given the difference in anthropometrics between participant and researcher there may have been a lack of comfort in sharing leisure pursuits.

4.7 Conclusion

The results from this study indicate that the leisure pursuits of persons with obesity are primarily sedentary in nature. Leisure among individuals in this study generally involved activities such as watching television and using the computer. Health behaviours tend to cluster, thereby providing some explanation of the association of being overweight and being more sedentary. Reasons for less active pursuits included personal, social and environmental influences. Based on the narratives reasons for more sedentary pursuits included limited physical tolerance for movement or exercise based leisure, accessibility and appearance in public. If places and spaces are not convenient, use is limited; if social identity is impaired so too are active pursuits (Henderson & Bialeschki, 2005). Efforts must be made to improve the built environment and decrease stigma to increase leisure engagement and socialization for persons with obesity. Since leisure is important for both physical and mental health, access and opportunity in this population must be explored. Participants also spoke about “*how they used to be*” and how in the past they could do much more than they do now. This corresponds with the medicalized view of aging and illness which is embedded in society - biological decline with increased dependency on others (Dionigi, Horton & Bellamy, 2011). Adults are spending their free time being sedentary rather than being physically active (Henderson & Bialeschki, 2005).

Discrimination in society toward this population continues to increase serving only to broaden the inequalities in all aspects of life. According to Liechty et al. (2006), the problem of limited active leisure pursuits is two-fold: people limit participation because they are dissatisfied with their bodies and there is tremendous societal pressure to conform to an often unrealistic ideal of beauty. A societal change in attitude of what

constitutes beauty is necessary, and an ecological not an individual approach must be taken. Overweight and obesity are complex issues with an ongoing to need to research the interrelationships between the individual, environmental and social influences. There are a multitude of mediating factors that impact leisure pursuits and well-being – physical ill health, lower levels of physical activity, accessibility and access, socioeconomic factors, and social supports. Research is necessary to understand the leisure experience of people with morbid obese as a first step to the development of interventions to improve well-being and quality of life. Further research considering all of these ecological factors is necessary to understand the constraints and supports to participation in leisure and achievement of enjoyment among obese individuals. More research is needed into exploring the leisure experiences, pursuits and restrictions of persons who are obese.

Chapter 5: Discussion and Conclusion

The purpose of this qualitative study was to understand and explore the hospital experience of persons with morbid obesity in an urban centre. The study provided an opportunity for patients with obesity to share their stories and experiences. In this chapter findings and limitations of the research are discussed. Concepts for future research and practice are also presented. The narratives of this study serve as a means to initiate change and improve health care environments in terms of access and professionalism in the health treatment of marginalized groups.

One-on-one interviews were conducted with nine participants, to explore the experience of hospitalization. Interview questions pertained to typical daily experiences, experience with the health care system and its providers, perceptions of the quality of care received during hospitalization, perceptions and experience with the equipment and physical environment during hospitalization, and communication with medical staff. The narratives of the nine participants represent reality within a social construct. The stories shared are shaped by experiences, values, family, community and social supports. Self-management (including emotional and physical health), the environment (built and social), communication with health professionals and the ability to participate in and access leisure emerged as the major themes of the study.

It is a common assumption that people with obesity are lazy, lack motivation, lack self-discipline and are non-compliant (Puhl & Heuer, 2009). According to Puhl and Heuer (2010) in addition to disrespectful treatment and negative attitudes from providers, gowns, examination tables and other medical equipment are commonly too small to be

functional for their body size (e.g., toilets are too low and are not reinforced, showers are too narrow and thresholds too high). And not only is the equipment not functional, there is lack of space to store and maneuver the chairs, beds and patient lifts. These issues with inappropriate equipment and physical space were found in the current study. The built environment should not impact on the health and support available to an individual during a time of illness. The environment should foster the people's needs so they can focus on regaining health and wellness. The limitations of the built environment however were not isolated to institutional settings; several participants spoke of barriers within their homes that excluded them from participating in the outside world. This shielded them from social endeavors simply adding to social isolation and associated issues (e.g., depression).

Obesity has also been linked to increased risk of death, disability and disease and has also been considered a major contributor to premature morbidity and mortality (e.g., Peeters et al., 2003). Yet obesity as a chronic health issue is virtually ignored in the majority of hospitalized patients. The position is taken that although obesity is at the root of the problem it is not the presenting problem and more urgent medical issues need to be addressed. Subsequently obesity is left for the patient's family physician to address (Hamdy, 2010). Findings of this study reiterate the medical model of care in our institutions. Participants were treated for their admitting diagnosis, without consultation with a dietitian or recommendation of lifestyle modifications. Obesity is a sensitive issue, which necessitates time, counselling and support. However, patient-centered care with patients who are obese does not often occur in part due to obesity stigma. In a study by Huizinga et al. (2009), alienation is evident with the prevalence of low respect towards patients increasing per 10 kg/m² increase in BMI.

Stigmatization of the individuals with obesity poses threats to their physical, emotional, social and psychological well-being, making obesity a matter of public health (Puhl & Heuer, 2010). Exploitation is evident in the widespread nature of weight discrimination within our society, with the issue mimicking racial discrimination (Carels & Musher-Eizenman, 2010). Issues of discrimination and stigmatization are evident within the health care system. The problem is that provision of information is often a product of respect; subsequently persons of size may not be receiving adequate treatment. It is not appropriate to blame people who are obese or view them as lazy and unmotivated; each person's story and circumstances are different. This was evident in the current research with various ages, living situations, employment status, leisure interests, and supports in only a small sample of the population from an urban centre. Education at the public health level and enabling communities to address issues related to obesity are necessary to both combat health concerns and encourage acceptance at every size. The environment must be accommodating and inviting from a physical, emotional and psychological perspective during the process of treatment, prevention and acceptance. Language is also an important factor to consider when creating an inviting and accommodating environment. It is necessary for all health professionals to remember that there are many facets to a person aside from their weight (Rowen, 2006). Language can have a powerful effect on patients and repeated use of derogatory terms carries a negative connotation. "Person with obesity" versus "obese person" helps address the psychosocial aspect of working with this population by seeing the person not weight or disability first. This is critical to how patients seek and obtain health care and follow the prescribed plan.

Overall this study found that participants' acute hospitalization experience was acceptable, with reasonable care being provided. This is in contrast to existing literature which has found that the hospital experiences and quality of care received among persons with morbid obesity to be poor due to lack of equipment, lack of time and blame (Poon & Tarrant, 2009; Thuan & Avignon, 2005). Although participants' had an adequate hospital experience in terms of their presenting conditions, this study highlighted several negative factors associated with the experience. For example, communication was limited, beds were too high, appropriate chairs were not available, and nurses were busy and disorganized; all factors that are consistent with the literature (e.g., Poon & Tarrant, 2009; Thuan & Avignon, 2005). Something that was striking in this study was complacency. Participants just accepted that if you rang the buzzer it would be a period of time before a nurse would respond; so many just did not ring. Participants stated they "*did not want to bother them, they had enough to do*" or they simply relied on family. Participants did not feel this was because of their weight, they thought it was how everyone was treated as there was not enough staff to quickly tend to patient needs. A common theme among the participants of this study was their support networks. Whether it was family or friends, all spoke highly and even emotionally about how fortunate they were to have someone they could rely on. Support is important in all aspects of life, especially during ill-health.

Activity is often encouraged as a health strategy for obesity yet is often not possible due to related issues such as joint pain and compromised breathing. As attempts at activity are not successful then there is a decreased tendency to continue to pursue the activity. Society emphasizes the thin ideal through promotion of exercise and healthy eating. For many of the participants in this study movement was a challenge. The ideal

for these participants was movement rather than exercise to allow for improved quality of life through increased independence. The importance of exercise and regular physical activity for maintaining health depends on who is defining health and leisure; the person, the researcher, the government or the practitioner. The importance of physical activity in reducing weight was understood by the participants; however, their immediate goals were not to be able exercise but to have increased mobility to be able to participate in daily and valued life activities.

There is no doubt that obesity has an impact on individual health, the health of society and the health of our nation. The overall findings of this study give insight into the lives of persons with obesity in their own words. It is evident there are challenges at home, at work and in hospital. It is also evident that quality of life and quality of care can be improved upon with simple approaches of seeing the person first, rather than obesity, and through minor adjustments in the environment. Bariatrics is a relatively new and emerging field so further study in all aspects is warranted. Of the research that does exist, there are significant gaps, with the person with obesity's voice seldom heard. Qualitative research is valuable as it empowers the participants and gives meaning to the data; using quantitative methods does not capture the emotion or humanness of the disease. Further research collaborating with the persons of concern is necessary, a "problem" cannot be addressed if the issue is not known and the voices are not heard.

5.1 Study Limitations

This study contains several limitations. The participants in this study were all mobile; seven were ambulatory, two were independent wheelchair users. All but one

participant was living within their own home and all were still able to engage in occupations related to self, such as toileting, feeding, dressing (partially) and communicating. All participants had support networks – family and friends up on whom they could call as needed. Subsequently during their hospitalization they did not require “intense” nursing care. Although previous research suggested a preponderance of hospital based discrimination and stigma (Puhl & Heuer, 2009, 2010), participants did not express evidence of such during their accounts. It is possible that individuals with a higher level BMI must be targeted to receive responses that parallel existing research. Considering the study took place in the province of Newfoundland and Labrador which has the highest rate of obesity in Canada, obesity stigma may not be as prevalent among this health care community. There may have been an element of embarrassment or discomfort as body type is a sensitive topic particularly amongst persons who are obese who are often marginalized and exploited. This may have limited the amount of information shared, especially considering the anthropometrics of the researcher (BMI of 20.0) versus the subjects being researched (BMI of greater than 40). According to Miller and Glassner (2006), these differences do not necessarily mean the interview is devoid of valuable information, it may have provided an opportunity to articulate feelings about their experiences. The difference in anthropometrics also allows the researcher to reflect on groups that are devalued by the larger culture. Through this reflection a broader understanding of the challenges faced by this population may be elicited. Whereas Rice (2009) states that when conducting research on sensitive subjects, differences in appearance and physical difference may affect encounters as there is an apparent privilege associated with being of a gendered size norm.

Even though saturation was determined to have been reached, the sample size was small which must be considered when reviewing the results. There were three other patients who initially expressed interest then declined participation. One participant declined after reading the form letter, another declined after her hospital stay was prolonged due to ongoing illness and an uncertain discharge plan, with a third participant declining once at home due to multiple visits to emergency for ongoing medical issues.

As both an occupational therapist and graduate student, there was some confusion amongst participants as for whom I was conducting the research. In some cases it appeared first and foremost that I was a health professional, resulting in participants thinking that I was conducting research for the hospital and not as a graduate student. This provides a reasonable explanation as to why the three potential participants were hesitant and subsequently declined to be interviewed. Also as an employed individual, the participants may have viewed me as a member of a different social class; yielding a hierarchy of socioeconomic status and additional reluctance to share detailed information. Both my profession and economic status may have limited the information that participants felt comfortable sharing.

There was some consideration given to conducting focus groups, as focus groups have the advantage of collecting data from a number of participants in a short period of time (Morgan, 2004). Focus groups however involve mutual self-disclosure because of the group interaction and some topics are just unacceptable to be discussed in a group situation. For persons with obesity, many of whom feel marginalized and discriminated against, a group setting to discuss one's experiences would likely not be appropriate.

Therefore, in-depth interviewing was selected as the method of data collection for this study.

5.2 Recommendations for Future Research

Additional research identifying factors associated specifically with persons with obesity is needed. It is recommended that larger persons be studied as the participants in this current study all had mobility and were able to participate in activities of daily living. The participants studied in the existing literature were much larger in size and more limited than those who participated in the current study.

There are multiple areas that are not well studied or understood and other areas that are just emerging. Obesity is not recognized as a chronic illness (Wagner et al., 2001) and physician expectations are often unrealistic (Dutton et al., 2010). The development of a chronic care model for the treatment of obesity is necessary. Physician expectations need to be better understood, as does their training in the treatment of obesity (Dutton et al., 2010). Research in acute, clinic and outpatient care is needed. Gender differences in treatment need also to be explored (Foss & Sundby, 2003). Increased knowledge of ecological factors and the association with participation in society and the workplace is also warranted. More research in all aspects of life from work, to leisure to hospitalization of people with obesity and morbidly obesity is required.

Many of the participants commented they did not feel that the negative aspects of their treatment were due to their size; they felt it was a factor of the organization and that all patients were treated similarly. Including a group of persons who are not morbidly in future studies would allow for the comparison of the hospital experience. Use of a

comparison group with which to compare perceptions of hospitalization may provide valuable information on whether the challenges associated with care for this population are at a system (i.e., issues with quality of care for all patients) or at personal level (i.e., obesity stigma and discrimination).

When feeling unwell and in an unfamiliar environment, it is not uncommon for memory or recall of events to be affected. Therefore there may have been important details that the participants did not recall and subsequently did not share in their narratives. Besides conducting interviews, to enhance the narratives shared, participants may have been asked to keep a diary of their experiences which may highlight valuable experiences that could enhance the overall data collected. Diaries prior to surgery can also be included in the methodology for those patients scheduled for procedures such as gastric bypass or joint replacements; with journaling continuing during hospitalization to further enhance sharing of the patients perceptions. Future studies need to include a larger sample size, use a mixed methods approach, interview subjects more than once, compare perceptions between patients and care providers and include a greater range of BMI's.

5.3 Conclusions

Obesity is increasing in prevalence and becoming an increasingly important item on the public health agenda. Decreasing sedentary lifestyles must become top priority. Research shows an increase in sedentary lifestyles with the advent of technology. Environmental challenges exist for persons who are obese which result in decreased participation in interpersonal relationships, valued life activities and in the work force. This population also experiences barriers to basic daily living tasks. People are

discriminated based on size not on their skills. With inactivity, increased weight and decreased participation in interpersonal relationships and the workforce, physical and mental illness often results. Thus the antecedents of obesity are further enhanced as consequences of obesity; a cycle develops that often requires intervention to be broken. Illness in this population is often impacted by bias and lack of accommodation in care facilities; failure to provide seating, beds, instruments and diagnostic equipment that accommodate larger people so their health issues can be properly assessed (Camden, Brannan & Davis, 2008). Sensitivity training and a team approach to care in both hospitals and the community are also warranted.

Studies exist regarding the challenges faced by health professions in working with persons with obesity but limited information is available from the patient's perspective. The current study aimed to explore the experiences of hospitalization from the patient's point of view, in particular persons with morbidly obesity that were defined as having a BMI of greater than 40. To my knowledge, this is the first study to explore the perceptions of care and stigma from the perspective of the patient. In this study it is evident that the obese population faces multiple challenges at both a personal and societal level. Social isolation, health care discrimination, environmental barriers, limited leisure pursuits contribute to increased mortality and morbidities exist. Participation for individuals with obesity includes real and perceived barriers (Forhan et al., 2010). Tension exists between what is important to adults living with obesity and the opportunities to participate in meaningful activities (Forhan et al., 2010).

From the data collected the overall perception of hospitalization was positive with reasonable care being provided. However narratives about gaps in communication,

equipment and the environment were prominent. Although a specific population was studied, some of these issues are not isolated to people with obesity. Communication for example and timing of care can be seen as a challenge for all. There is a need to recognize diversity in individuals in their interpretations and experiences of all aspects of life, especially in healthcare due to the immense vulnerability faced. Recognizing and understanding this diversity will help in establishing equal non-stigmatized care for all.

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APPENDIX A: LETTER TO REQUEST PARTICIPATION



Dear Potential Participant

I am student enrolled in the Master of Science in Kinesiology program at Memorial University. To complete this degree I am doing a study called Perceptions of Hospitalization: A qualitative study of persons with obesity. I am interested in this topic as I work with people who are obese in my job as an occupational therapist at the Health Sciences Centre and St. Clare's Hospital in St. John's.

The aim of this study is to gain an understanding of obese people's experiences during an admission to hospital in terms of attitudes, quality of care from health professionals, equipment, space, tests and discharge planning. Research is limited in this area. The current information on hospital experience is from the perspective of the health professional, including, doctors, nurses and therapists. There is little information available from the perspective of the patient. In sharing your story about your hospital stay the goal is to outline the process of hospitalization to ensure that the best and most compassionate care is being provided to all patients.

Your participation in this study would involve about 60-90 minutes of your time. During this time, you would be asked to provide demographic information (including your age and length of stay in hospital), and you would be interviewed. The interview would take place in a quiet and comfortable location that is convenient for both the participant and the researcher (i.e. does not require more than 90 minutes of travel each way). The interview will be digitally recorded. If you do not wish to be recorded then you should not volunteer for the study. There may be a second meeting if you choose so, to review the interview and the interpretation of the information you provided. At any time during this research you may ask questions and/or no longer participate. There is no reward for participating in this study, it is strictly voluntary.

If you would like to be contacted for an interview, please complete the attached sheet or contact the researcher by email karen.martin@easternhealth.ca or by telephone at 727-1714.

Sincerely,

Karen Martin
MSc Candidate

Please provide your name, address, email and time of day you may be contacted. A researcher will call you to arrange a time and place for the interview. If you have any questions, please email karen.martin@easternhealth.ca or telephone at 727-1714. Thank you for providing your contact information showing you are interested in participating in this study.

Name: _____

Address: _____

Telephone:
(home) _____

(work) _____

(cell) _____

Email:

Preferred time of contact:

Preferred method of contact (i.e. email, home phone, work phone, etc.):

APPENDIX B: STATEMENT OF ETHICAL ISSUES

STATEMENT OF ETHICAL ISSUES

Harms and Benefits

Harms: There should be minimal harm associated with participating in this study. Participants may experience some emotional discomfort associated with sharing narratives related to the experience of hospitalization. There is not expected to be a long term effect associated with this emotional discomfort. There may also be some stress associated with the time to complete the interview and meeting face-to-face with the interviewer. If the participant would be more comfortable with a family member or friend accompanying them, this will be permitted. There is no pressure to participate in this study, it is purely voluntary. The health professional-patient relationship will not be impacted by participation in this study; knowledge of their participation will not be disclosed. If medical or psychosocial issues arise during the interview (that may require the attention of a health professional), the researcher, with consent of the interviewee, will help the interviewee arrange assistance.

Benefits: Participants may feel benefit from participating in this study knowing that their story and perceptions are being heard. People benefit from feeling that their opinion matters. Future benefits may include provision of a more supportive healthcare environment including improved interactions with staff, appropriate equipment and more adequate physical space.

Free and Informed Consent

Competence: Participants will be given an informative description of the study when their consent is requested. All potential participations will be informed that participation is voluntary and there will be no judgments or repercussions should they choose not to participate in the research. Participants will also be assured that they may withdraw at anytime from the study without repercussions, harm or penalty.

Free Consent: There will be no pressure to participate in this study. There is no monetary gain to be achieved by participating in this study. It is purely voluntary. Participation in this study is not affiliated with treatment or care provided by any health professional. Potential subjects for this study will be approached and provided with a form letter which they voluntarily chose to return with contact information (i.e. phone number, address and email) if they are interested in scheduling an interview. Interview

consent forms will be completed prior to the start of each interview. Subjects will also be recruited through poster advertisements in physician's office. On a voluntary basis they may phone or email the primary investigator inquiring about the study and/or volunteering to participate. Participants may withdraw from the research study at any time without impacting their medical care and treatment.

Recruitment Process: Potential participants will primarily be recruited during hospitalization in one or both of the acute care facilities in St. John's, St. Clare's Mercy Hospital or the Health Sciences Centre. Potential participants will be identified by a health professional, other than me (to reduce bias) including physicians, nurses and allied health staff. If interested or wanting to know more about the study a form letter will be provided. The form letter (Appendix D: Form Letter) will outline the aim of the study and explain what is involved if in agreement to participate. Potential participants may also be recruited through poster advertisements at local family practice offices. Interested participants may contact the researcher by either phone or email and this information will be provided on the poster.

Administration of Interviews: Interviews will be administered in a private location of the participants choosing. A second party will be permitted to sit in on the interview, should the participant request such. If a second party does attend the interview, then a written oath of confidentiality will be required (Appendix D). Should the participant not be able to identify an appropriate space to complete the interview, a room will be designated at the Health Sciences Centre.

Informed Consent: All potential participants will be informed of the research and the research consent process. Provision of contact information gives the researcher consent to contact potential participants to schedule a time for an interview. Consent to proceed with the interview will be obtained in writing prior to each interview (Appendix E: Interview Consent).

Documentation of Informed Consent: Once a subject has provided contact information indicating their interest in participating in the research, they will be contacted by the primary research to schedule a time for the interview. Once a time has been scheduled the subject will be provided with a copy of the consent form to review the study description and ask questions as needed. Participants will be asked to bring the consent form with them where it will be signed and collected prior to conducting the interview.

Deception: No deception will occur.

Consent for aspects of the interviews: Participants will be informed that face-to-face interviews will be digitally recorded and that the recordings will be transcribed and

archived for a period of 5 years. If participants agree to participate in a face-to-face interview but wish not to have their interview recorded, there will be no interview.

Consent vs. Release: Participants agreeing to participate in the research are voluntarily agreeing to the research process outlined in the project summary.

Privacy and Confidentiality

I will attempt to maintain the privacy and confidentiality of all individuals participating in the research. However, anonymity cannot be guaranteed. To reduce issues of privacy and confidentiality:

- Data will be stored at Memorial University, in the Physical Education building for five years;
- Access to digitally recorded information only will be provided to the researcher and thesis supervisor who may help with transcription;
- Transcribed data will be kept in a separate location from informed consent;
- Data collected will only be used in relation to this research project;
- Participant's anonymity will be protected to the greatest extent possible. Pseudonyms of interviewees will be immediately selected, and any textual information (transcripts, notes) will refer to participating individuals by this name only. Consent forms will be given an identification code and will be stored separately.

Limits to confidentiality: Information collected in this study will be treated in a respectful and private manner. However, if anyone presenting information indicating that they may be in need of protective intervention or in need of other social support services, it is lawful that this information be reported to the appropriate authorities.

Conflict of interest: Participation in this study will not be disclosed by the researcher, so as to maintain the patient-healthcare professional relationship. It is worth stating that my position as an occupational therapist within Eastern Health, particularly in acute care may be a conflict of interest as it is possible that I may have treated one or more of the participants. If this is the case, the association with the participant will be documented so as to not impact on the overall results of the study. It is important to remember that this is a qualitative study so the issue of bias does not apply, thus the participants opinion is still valid regardless of the researcher also previously being a health care provider to the patient during an admission. It is also important to state that my anthropometrics – healthy weight female, may also impact on the research process. If this is the case, again it will be documented and discussed during analysis of the results.

**APPENDIX C: DEMOGRAPHIC INFORMATION AND
INTERVIEW GUIDE**

Participant #: _____

Participant Name: _____

Participant Age: _____

Address: _____

Phone Number: _____

Email Address: _____

Preferred Method of Contact: _____

Preferred Time of Day of Contact: _____

Family/Household Composition: _____

Occupation: _____

Weight/BMI: _____

Hospital of Admission: _____

Date of Admission and Discharge: _____

Length of Stay (LOS): _____

Reason for Admission: _____

Date and Time of Interview: _____

Location of Interview: _____

Member Checking: YES _____ NO _____

Participant Signature: _____ **Date:** _____

Researcher Signature: _____ **Date:** _____

Interview Guide

Person

Describe your typical day?

Does your body weight affect your ability to engage in activities of daily living?

How do you feel about your body weight?

Health

Would you describe yourself as healthy? Explain.

Do you visit your doctor often? Why or why not?

Have you had many admissions to the hospital? Why or why not?

Is your overall health impacted by your body weight?

Do you have frequent visits to your physician for health issues related to your body weight?

Do you have visits to the hospital for health issues related to your body weight?

Hospital

What is your experience with the healthcare system?

What is your experience with healthcare providers?

Did you face any challenges during your admission?

How were you treated during your hospital stay?

By doctors?

By nurses?

By rehab therapists – occupational and physical therapists?

By dietitians?

Was the staff professional when working with you?

Did you receive adequate care during your admission?

Probing questions – will present themselves depending on the nature of the conversation and will not be used unless needed.

Do you think you were treated differently because of your physical stature?

How does this impact your sense of self?

Was there equipment to meet all your needs during your stay? (I.e. transport, toileting, seating, sleeping, personal care and assessment needs)

APPENDIX D: WRITTEN OATH OF CONFIDENTIALITY



School of Human Kinetics and Recreation

The aim of this study is to gain an understanding of obese people's experiences during an admission to hospital in terms of attitudes, quality of care from health professionals, equipment, space, tests and discharge planning. Research is limited in this area. The current information on hospital experience is from the perspective of the health professional, including, doctors, nurses and therapists. There is little information available from the perspective of the patient. Participants may experience some emotional discomfort associated with sharing narratives related to the experience of hospitalization. There is not expected to be a long term effect associated with this emotional discomfort.

The participant, _____, that you have accompanied here today, has requested your presence during the interview to enhance their comfort with the experience. All of the information shared here today is strictly confidential. The information is not to be disclosed for any purpose outside of its use in the research analysis. Because of the possible sensitive nature of the information being shared here today, anonymity and confidentiality are a must.

You must exercise silence during the interview as you have not consented to participate. If you talk during the interview this may impact the data and the subsequent results of the study. If you feel uncomfortable during the session, with the permission of the participant you may leave at anytime. The oath of confidentiality however remains as documented.

In signing this document you agree to strict confidence of the information shared here today and at no time shall you disclose involvement in and /or information shared during this interview.

Participant

Date

Participant Accompaniment

Date

Researcher

Date

APPENDIX E: INTERVIEW CONSENT FORM



School of Human Kinetics and Recreation

Title: Perceptions of Hospitalization: A Qualitative Study of Persons with obesity

Researcher(s): Karen Martin, MSc Candidate, Occupational Therapist
Dr. Angela Loucks-Atkinson, Department of Human Kinetics and Recreation
Dr. Michelle Ploughman, Clinical Research Scientist, Eastern Health
Dr. Tim Fletcher, Department of Human Kinetics and Recreation
(All are affiliated with Memorial University)

You are invited to take part in a research project entitled, Perceptions of Hospitalization: A Qualitative Study of Persons with obesity.

This form is part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. It also describes your right to withdraw from the study at any time. In order to decide whether you wish to participate in this research study, you should understand enough about its risks and benefits to be able to make an informed decision. This is the informed consent process. Take time to read this carefully and to understand the information given to you. Please contact the researcher, Karen Martin, if you have any questions about the study or for more information not included here before you consent.

It is entirely up to you to decide whether to take part in this research. If you choose not to take part in this research or if you decide to withdraw from the research once it has started, there will be no negative consequences for you, now or in the future.

Introduction:

Thank you for volunteering to be interviewed and taking the time to read this form which explains the study I am conducting on the Perceptions of Hospitalization: A Qualitative Study of Persons with obesity. As part of my Master's thesis, I am conducting research under the supervision of Dr. Angela Loucks-Atkinson. The reason

for this study is to better understand the experience of admission to an acute care hospital for an obese person. I will write about the findings in my thesis and I hope to present my findings to health professionals working with obese individuals so as to strengthen the capacity to provide a supportive environment in terms of care and comfort and physical space and equipment. In learning about your experiences the goal is to help establish quality health care for all.

Purpose:

I am asking your consent to be interviewed for my study because I am particularly interested in your perspective. To be interviewed, you must be at least 19 years of age, have a body mass index greater than 40 and been admitted to hospital within the past 12 months. The interview will take approximately 90 minutes and includes about 10 questions about your experience during your hospitalization at either the Health Sciences Centre or St. Clare's Hospital.

Overview of Procedures:

If you agree to participate in an interview, I will digitally record the interview and type out your answers at a later date. I will also collect demographic information including age and length of stay in hospital prior to the start of the interview. This information should take a maximum of 10 minutes to collect. The purpose of this information is to allow comparison between interviews in terms of factors related to age and time in hospital and the possible relationship to the experience. Your information will remain confidential, as I will not share your information with other study participants or with anyone not involved in the study. Only my thesis advisor and a member of my committee will see the raw results of my study. I am simply interested in your perceptions of your hospital experience. The written transcripts from the interviews will be stored securely at Memorial University for five years after which they will be destroyed. The digital recording of the interview will be stored at Memorial University for one year, and then destroyed.

Risks & Confidentiality:

There are minimal risks associated with this study. Your participation is voluntary, and you can refuse to answer any questions during the interview without giving any reason and without ramifications, and you can choose to withdraw from the study at any time. You can ask to have all the information about yourself returned to you, removed from the research records, or destroyed. Personal identifiers will not be used in any part of the research process. Pseudonyms and identification codes will be used throughout the research process to protect the participants' anonymity. You may also

choose to participate in member checking. This involves reviewing the digital recording once it is transcribed and meeting with the researcher to confirm the accuracy of the document. You would be provided with a copy of the transcribed recording for review, and at your convenience a second meeting of 60 minute duration could be planned to review the text. There are no financial benefits for participating in this study. Through your participation, you may help make future care more compassionate and equipment more suitable for your needs. All data will be kept in confidence at the School of Human Kinetics and Recreation at Memorial University.

Compensation:

There will be no financial compensation for participation in this project.

Questions:

If you have any further questions or concerns, please feel free to contact me. I am best reached by email at karen.martin@easternhealth.ca or by phone at (709) 727-1714.

The proposal for this research has been reviewed by the Interdisciplinary Committee on Ethics in Human Research and found to be in compliance with Memorial University's ethics policy. If you have ethical concerns about the research (such as the way you have been treated or your rights as a participant), you may contact the Chairperson of the ICEHR at icehr@mun.ca or by telephone at 709-864-2861.

Consent:

Signing this form gives your consent to be interviewed. It tells me that you have understood the nature of the study and received satisfactory answers to your questions. By signing this form, you are agreeing to take part in the study but can leave the study at any time. If you choose to participate in the study by providing your consent on this form, please sign both copies. Keep one copy for your records and the other signed copy will be kept with your demographic information provided at the start of the interview.

I have read and understand the above information. I have had the opportunity to ask questions about the study, and my participation and rights. I consent to participate in the interview.

I would like the option of participating in member checking. ____ Yes ____ No

A copy of this Informed Consent Form has been given to me for my records.

Signature of participant

Date

Researcher's Signature:

I have explained this study to the best of my ability. I invited questions and gave answers. I believe that the participant fully understands what is involved in being in the study, any potential risks of the study and that he or she has freely chosen to be in the study.

Signature of Principal Investigator

Date