

Working with patients living with obesity in the intensive care unit: A study of nurses'  
experiences

Jacqueline Marie Shea RN, BScN, MScN

Thesis submitted to the Faculty of Graduate and Postdoctoral Studies in partial fulfilment of the  
requirements for the degree of Master of Science in Nursing

Faculty of Health Sciences  
School of Nursing  
University of Ottawa

June 24, 2014

© Jacqueline Shea, Ottawa, Canada, 2014

## Summary

Nurses who work in the intensive care settings (or units, ICU) in Canada encounter a growing number of patients living with obesity (PLWO) in clinical practice. Many authors suggest that the number of PLWO who are admitted to the ICU has increased significantly because obesity is on the rise in Canada. PLWO are thought to be at a higher risk for developing chronic illnesses and life-threatening complications that require an admission to the ICU. They are also more likely to develop postoperative complications that require life-sustaining treatments, invasive hemodynamic monitoring and evaluation, assistive devices, pharmacological interventions, parenteral nutrition, fluid and electrolyte management, and prolonged admission with associated risks of complications. Yet, there is limited research on the experience of nurses providing care to PLWO. The goal of this qualitative study was to examine the experiences of ICU nurses who work with PLWO and how these experiences affect the way they provide care. More specifically, this study was designed to describe and explore the inclusionary and exclusionary practices developed by nurses providing care to PLWO by drawing Canales' (2000) Othering framework. Lastly, an additional goal of this study was to document the needs of ICU nurses with respect to the care of PLWO and areas of improvement in the ICU. A total of 11 ICU nurses were interviewed for this study. Data analysis followed the principles of Applied Thematic Analysis (ATA) and revealed four themes. The first theme describes how the PLWO become "Other" in the ICU context. The second theme focuses on exclusionary Othering and how it manifests itself in the way PLWO are differentiated, cared for, and viewed in the ICU context. The third theme sheds light on inclusionary Othering in the form of strategies that are used by ICU nurses to engage with PLWO in a way that is inclusive and transformative. Finally, the last theme concentrates on the ICU environment itself and the resources available (or not available) to nurses, with a particular emphasis on the needs of nurses who provide care to PLWO.

## Acknowledgements

I would first like to acknowledge my thesis supervisor Dr. Marilou Gagnon and my thesis committee, specifically Dr. Jean-Daniel Jacob and Dr. Christine McPherson. To Dr. Marilou Gagnon, I would like to extend my gratitude and appreciation for your guidance, support, encouragement, patience and humour throughout this research process and learning experience. Most of all thank you for all your hard work I would not have made it here without you. Dr. Jean-Daniel Jacob and Dr. Christine McPherson, thank you both for sharing your thoughts, your research expertise and for providing constructive feedback throughout my thesis. I would also like to express my feelings of gratitude to Suzanne Nussey, thank you for time, your attention and your guidance in this experience.

To the ICU nurses who participated in this research study, I would like to express my appreciation and express how wonderful all of you have made this experience. To my fellow nurses and friends, it is because of all of you I am proud to be a nurse and I appreciate all the support that has been provided to me to complete my education through simple conversations or assisting me with changing my shifts so that I could attend classes. You are all amazing and I am fortunate to have had the experience of working with all of you. Mariko, thank you to my fellow nurse and master's student for all your support both emotionally and mentally. Thank you for reading and revising so many of my papers and assisting me to improve my writing skills. You are an amazing woman and friend.

Mom, thank you for helping to shape the person and nurse that I have grown into. Thank you for your encouragement and support, I would not have been able to achieve many of my life goals without you. Thank you for teaching me to persevere and to keep trying even if you may not succeed they were valuable life lessons. Gram and Grandad, thank you both for all the emotional support and for passing on your love of learning and the importance of education.

## Table of Contents

<b>Summary .....</b>	<b>ii</b>
<b>Acknowledgments .....</b>	<b>iii</b>
<b>Table of Contents.....</b>	<b>iv</b>
<b>Figures.....</b>	<b>vii</b>
<b>Tables .....</b>	<b>viii</b>
<b>Chapter 1. Research Problem .....</b>	<b>1</b>
1.1 Research Problem.....	1
1.1.1 PLWO in the ICU Context .....	1
1.1.2 PLWO in the Health Care Context.....	4
1.2 Research Question .....	8
1.3 Research Objectives.....	8
1.4 Epistemological Position .....	9
<b>Chapter 2. Literature Review .....</b>	<b>12</b>
2.1 Obesity : A Brief Description .....	12
2.2 Epidemiology .....	13
2.3 The “Obesogenic” Environment .....	14
2.4 Social Construction of Obesity .....	14
2.5 Medical Construction of Obesity .....	21
2.6 Health Care Context .....	25
2.7 Providing Nursing Care to PLWO .....	27
2.8 Attitudes and Perception of Nurses.....	29
2.9 Impact of Experience on Attitudes and Perceptions of Nurses.....	32
<b>Chapter 3. Theoretical Framework.....</b>	<b>36</b>
3.1 Background .....	36
3.1.1 Symbolic Interactionism .....	36
3.1.2 Stigma .....	37
3.2 Othering : The Framework .....	38
3.2.1 Othering Practices .....	39
3.2.2 Inclusionary Practices .....	41

3.2.3 Exclusionary Practices .....	42
3.3 Othering in the Nursing Literature .....	44
3.3.1 Interprofessional Communication, Power and Hostile Workplaces .....	45
3.3.2 Immigration and Racism .....	45
3.3.3 Race and Identity .....	46
3.3.4 Nursing Education, Nursing Research and Cultural Competence.....	47
3.3.5 Nursing Practice: Psychiatry, Forensic and HIV/AIDS .....	48
3.3.6 Obesity.....	49
<b>Chapter 4. Methodological Considerations.....</b>	<b>51</b>
4.1 Research Design .....	51
4.2 Research Setting .....	53
4.2.1 Research Sites.....	54
4.2.2 Values and Standards.....	56
4.2.3 Nursing Care.....	57
4.2.4 Physical Environment and Resources.....	59
4.3 Recruitment .....	60
4.4 Sample .....	62
4.5 Data Collection .....	63
4.6 Data Analysis.....	65
4.7 Rigor.....	67
4.8 Ethical Considerations .....	70
<b>Chapter 5. Research Findings.....</b>	<b>74</b>
5.1 Working with the Other .....	75
5.2 Exclusionary Othering in the ICU.....	80
5.2.1 Protecting Yourself.....	80
5.2.2 Not Being Able to Provide Care .....	86
5.2.3 Witnessing Instances of Obesity Biases.....	92
5.3 Inclusionary Othering in the ICU .....	98
5.3.1 Keeping Your Distance .....	98
5.3.2 Getting to Know Your Patient.....	101
5.3.3 Role Taking.....	104

5.4 ICU Environment .....	106
5.4.1 Resources.....	107
5.4.2 Working With Each Other.....	112
5.4.3 Needs .....	115
<b>Chapter 6. Discussion .....</b>	<b>118</b>
6.1 Where Nurses Work and How They Feel About Their Work Matters.....	119
6.2 How Nurses Relate to Patients, Colleagues, and Context Matters.....	123
6.3 Limitations of the Study .....	126
6.4 Implications of the Research Findings .....	127
6.4.1 Implications for Education .....	127
6.4.2 Implications for Nursing Practice.....	128
6.4.3 Implications for Research.....	129
6.4.4 Implications for Nursing Theory.....	130
<b>Conclusion .....</b>	<b>132</b>
<b>References .....</b>	<b>133</b>
<b>Appendix A. Research Ethics Board Approvals .....</b>	<b>155</b>
<b>Appendix B. Recruitment Posters .....</b>	<b>158</b>
<b>Appendix C. Pre-Interview Questionnaire .....</b>	<b>161</b>
<b>Appendix D. Interview Guide.....</b>	<b>164</b>
<b>Appendix E. ICU Research Committee Consent.....</b>	<b>166</b>
<b>Appendix F. Consent Forms .....</b>	<b>168</b>

**Figures**

Figure 1. Identification and differentiation.....	40
Figure 2. Overview of research findings .....	74

**Tables**

Table 1. Ages of RNs working in the research setting .....	55
Table 2. Characteristics of research participants .....	62
Table 3. Rigor criteria.....	67
Table 4. Needs of ICU nurses .....	116
Table 5. Key strengths of the study .....	127

## CHAPTER 1

### RESEARCH PROBLEM

#### 1.1 Research Problem

##### 1.1.1 PLWO in the ICU Context

The intensive care unit (ICU) is a fast-paced, stressful, demanding and highly technological environment (McGrath, 2008; Reto, 2003) where nurses require additional education and knowledge to safely provide nursing care to critically ill patients. ICU nurses provide one-on-one care to patients with complex needs (physical, emotional, spiritual, psychosocial) and medical conditions that require life-sustaining treatments, ongoing diagnostic tests, invasive hemodynamic monitoring and evaluation, assistive devices, pharmacological interventions, parenteral nutrition, fluid and electrolyte management, and prolonged admission with associated risks of complications. Providing nursing care in the ICU context is a challenge because of patient acuity, complex care needs, physical demands, ever-changing clinical situations, and competing priorities (Reto, 2003). For these same reasons, nurses may encounter additional challenges when caring for a person, persons or patients living with obesity (henceforth – PLWO) in the ICU context (Reto, 2003).

According to the World Health Organization (WHO, 2012), obesity is defined as an “abnormal or excessive accumulation of body fat which may impair health” (p.1). Obesity in adults is primarily defined through the use of the body mass index (BMI) (WHO, 2012). The BMI is calculated by a person’s weight in kilograms, which is then divided by his/her height in meters squared ( $\text{kg}/\text{m}^2$ ) (Health Canada, 2006; WHO, 2012). People who are identified as obese have a BMI of 30 or greater, and those who are considered morbidly obese have a BMI greater than 40 or are 100 lbs. above their ideal body weight (Health Canada, 2006; Smith, 2008; WHO,

2012). The BMI is considered to be the standard measurement for defining obesity, yet the literature has noted that this measurement has a number of limitations (Wright, 1998) and was originally developed for use in population studies, not for individual diagnosis (Rail, 2012). Despite these limitations, the BMI continues to be used as the primary tool to define obesity.

Researchers have found that the physical demands associated with providing care to PLWO who are critically ill increase just based on the weight of the patient alone (Hahler, 2002, Reto, 2003). The same relationship has been described with respect to patient weight and key dimensions of ICU nursing such as patient acuity and complex care needs (Reto, 2003). Additionally, ICU nurses working with PLWO may face important challenges when providing life sustaining treatments such as vasopressors, assisting with diagnostic tests such as chest x-rays, ensuring hemodynamic monitoring and evaluation using central venous pressure, assistive devices such as ventilators, pharmacological interventions based on weight calculations, organizing parenteral nutrition as well as fluid and electrolyte management based on individual needs, and implementing preventive measures to diminish the risk of complications related to prolonged ICU admissions which are common in this patient population. Additionally, ICU nurses working with PLWO who are unstable may encounter important difficulties when obtain intravenous access, accurate readings of blood pressures, maintaining airways or doing chest compressions (CPR) (Reto, 2003).

ICU nurses in the United States and in Canada encounter a growing number of PLWO in clinical practice. This trend is consistent with the increasing weight and BMI of the general population (Bochicchio et al., 2006; Kiraly, Hurt & Van Way, 2011; Poon & Tarrant, 2009; Zuzelo, 2005; Zuzelo & Seminara, 2006). Over the past 25 years, the number of children and adults who are considered to be obese has increased greatly in Canada (Health Canada, 2006; Tremblay, Katzmarzyk & Willms, 2002). Katzmarzyk (2002) observed that in a 13 year period,

the prevalence of obesity in Canada nearly tripled. In 1985, the prevalence was 5.6% which increased to 9.2% by 1990, 13.4% by 1994, 12.7% by 1996, and 14.8 % by 1998 (Katzmarzyk, 2002). According to Luo and colleagues (2007), the prevalence of obesity in Canada increased from 10% in 1970 to 23 % in 2004 with an overall increased in weight in men and women occurring in all provinces. In 2006, two out of every three Canadian adults were considered obese (Health Canada, 2006).

Many authors suggest that the number of PLWO who are admitted to the ICU will continue to increase as the numbers of Canadians who live with obesity continue to increase (Bochicchio et al., 2006; Kiraly et al. 2011; Poon & Tarrant, 2009; Zuzelo, 2005; Zuzelo & Seminara, 2006). The rise in the number of PLWO admitted to the ICU, and its implications for clinical practice, have recently been reported in the media, more specifically in an article entitled “*Caring for obese patients poses daunting challenges: Intensive care units are reporting a rise in the number of patients with extreme body weight,*” published in *The Montreal Gazette* (Kirkey, 2011). This newspaper article noted that the percentage of PLWO admitted to the ICU in the United States was 31.1 and that this percentage paralleled the prevalence of obesity in the country. Considering that the prevalence of obesity in Canada is 24.1% (Shields, Carroll & Ogden, 2011), it is safe to argue that providing care to PLWO is now an integral part of nursing care in the ICU.

PLWO are thought to be at a higher risk for developing a number of illnesses and diseases when compared to normal weight persons (Bovbjerg, 2008; Charlebois & Wilmoth, 2004). These illnesses and diseases include high blood pressure, coronary artery disease, angina pectoris, congestive heart failure, type 2 diabetes, insulin resistance, glucose resistance, hyperglycemia, dyslipidemia, strokes, gallbladder disease, colon cancer, osteoarthritis, gout, lower back pain, gall stone disease, liver cirrhosis, bladder control issues, dermatitis, and sleep

apnea and other respiratory problems such as asthma (Charlebois & Wilmoth, 2004; Grindel & Grindel, 2006; Health Canada, 2006). Women are at increased risk of complications during pregnancy, reproductive health issues, and cancer (Charlebois & Wilmoth, 2004; Grindel & Grindel, 2006). PLWO who are admitted to hospital are also more likely to develop complications including thromboembolic disease, myocardial infarctions, respiratory failure requiring mechanical ventilation, sepsis, surgical morbidity associated with wound complications, and sudden death after minor surgical procedures (Shikora, 1997).

As a result of complications and more complex health issues, PLWO have longer lengths of stay in ICU and require mechanical ventilation for longer periods of time (El-Solh, Sikka, Bozkanat, Jaafar & Davies, 2001). In addition, they have a higher mortality rate (30% versus 17%) than patients with lower BMIs (El-Solh et al., 2001). When PLWO are critically ill, they present an increased rate of morbidity and mortality (Bochicchio et al., 2006). For PLWO the higher the person's BMI, the higher the possibility that they will be affected by the illnesses previously mentioned (Charlebois & Wilmoth, 2004). This not only impacts their overall physical health but also the type of care required and the level of complexity that needs to be addressed when planning nursing care in the ICU context (Bochicchio et al., 2006). At times, this may result in increased difficulties providing safe, competent, supportive and high quality nursing care to this patient population (Bochicchio et al., 2006). Yet, there has been very limited research on the experience of nurses providing care to PLWO. Explorative and descriptive studies published to date are almost exclusively focused on the care provided to PLWO in other settings or in the health care system more generally.

### **1.1.2 PLWO in the Health Care Context**

The association between obesity and health problems has been portrayed as very simple cause and effect, when in actuality it is an extremely complex and multifactorial phenomenon (Rail,

2012). The media have described a direct, positive and strong correlation between the BMI and morbidity and mortality rates (Gaesser, 2003; Gard & Wright, 2005; Lenz, Richter & Muhlhauser, 2009; Mark, 2005; Rail, 2012). Social views of obesity have also come to be associated with the idea that obesity arises from inactivity, poor eating habits and individual choice (Rail, 2012). In society, these views are not uncommon, and they disregard the influence of social, cultural, structural, and economic factors on eating habits, access to healthy and affordable foods, lifestyle changes, life priorities, and the production of “obesogenic” environments (Rail, 2012). (This latter concept will be defined in more detail in Chapter 2.) It should be emphasized that the causes of obesity have not been clearly established, and that a complex set of causes and factors beyond individual control, including genetic or environmental factors, often are disregarded (Astrup, Hill & Rossner, 2004; Boero, 2009; Chambers & Wakley, 2002; Rosmond, 2004; Wright, 1998).

In recent years, the construction of obesity as a public health and medical problem has been fueled by epidemiological studies that report an “obesity epidemic” and by growing attention to the rapid growth of obesity prevalent in Western societies (Rail, 2012). These phenomena have resulted in the physical condition of persons with BMI’s over 30 being constructed as “risky” and unhealthy, although they may otherwise be healthy (Rail, 2012). Additionally, the social construction of obesity as a personal and moral failure has resulted in PLWO being perceived as lazy, unmotivated, lacking self-discipline, incompetent, non-compliant and sloppy (Puhl & Brownell, 2001, 2003; Rich & Evans, 2005; Roehling, 1999; Teachman, Gapinski, Brownell, Rawlins & Jeyaram, 2003). Making the issue of obesity even more complicated, research also points to the racialization and genderization of the obesity epidemic, with strong associations to so-called unhealthy or irresponsible lifestyles (Boero, 2009). Puhl and Heuer (2009) explain that that “these views are rarely challenged by Western society,

leaving persons living with obesity vulnerable to social injustices, unfair treatment and impaired quality of life as a result of substantial disadvantages and stigma” (p.1).

The substantial disadvantages and stigma faced by PLWO include, but are not limited to, injustices, unfair treatment, and inequalities in areas of education, employment, health care and social life (Bovbjerg, 2008; Puhl & Brownell, 2001, 2003, 2009; Roehling, 1999; Teachman et al., 2003; Vacek, 2007). Here it is important to highlight that the construction of obesity as a condition that relates to personal control, discipline and responsibility plays an important role in creating these disadvantages (Boero, 2009; Cohen, Perales & Steadman, 2005; Ernsberger, 2009; Lang & Rayner, 2007; Puhl & Brownell, 2001, 2003; Rich & Evans, 2005; Roehling, 1999; Sykes & McPhail, 2011; Teachman et al., 2003). Current research suggests that obesity not only impacts social life and opportunities to be an active member of society, but also impacts personal life; this can result in lower self-esteem, psychological distress, depression, body image dissatisfaction, anxiety, major depression, suicidal ideation and suicide attempts (Beausoleil, 2009; Carpenter, Hasin, Allison & Faith, 2000; Kivimaki et al., 2009; Puhl & Heuer, 2009; Reilley et al., 2003; Vacek, 2007). Therefore, it is important to recognize the intersections between one’s social experiences and personal experiences when looking at health outcomes in PLWO.

Nurses and other health care providers are not immune to the social construction of obesity and the prevailing views about PLWO. So it is not uncommon for PLWO to encounter negative attitudes and perceptions in health care settings (Falker & Sledge, 2011; Puhl & Heuer, 2009). The literature has demonstrated that there are a number of negative attitudes held by nurses towards PLWO (Puhl & Heuer, 2009). Some nurses perceive PLWO as lazy, lacking self-control, non-compliant and lacking willpower (Brown, 2006; Puhl & Heuer, 2009). The nurses’ perceptions and attitudes towards these patients reflect those present in Western

society. Research has shown that the degree to which nurses hold negative attitudes and perceptions about PLWO can be affected by their professional education, age, personal weight and previous clinical experiences (Bagley, Conklin, Isherwood, Pechiulis & Watson, 1989; Culbertson & Smolen, 2011). In a study conducted by Culbertson and Smolen (2011), older nurses with more professional education and younger nurses with less clinical experience held more positive attitudes towards PLWO. In addition, nurses who were unhappy with their own body weight and size often viewed PLWO more negatively (Culbertson & Smolen, 2011).

Not all research supports the contention that health care providers perceive PLWO negatively. Some studies report that nurses had positive attitudes and perceptions of PLWO (Puhl & Heuer, 2009). For example, Zuzelo and Seminara (2006) found that nurses were mindful of and strived to provide respectful patient care for PLWO. The goal of the study undertaken here is not to dismiss findings of positive attitudes and perceptions of PLWO in health care settings, but to acknowledge, as documented by Amy, Aalborg, Lyons and Keranen (2006), that this patient population continues to report disrespectful treatment, negative attitudes from others, situations that cause them to feel embarrassment, and unsolicited advice to lose weight from nurses and other health care providers. These experiences can result in higher incidences of health care delay, avoidance of preventative health care, increased illness burden, discomfort during health care interactions, and overall decreased levels of physical, mental, psychological, and emotional health (Thompson & Thomas, 2000; Wee, Phillips & Cook, 2002). In a closed environment, such as the ICU, these experiences could have additional effects on health outcomes and quality of care.

Of particular relevance to this research problem are the findings reported by Culbertson and Smolen (2011). These authors found that nurses providing care to PLWO often experienced physical discomfort and exhaustion, which contributed to their views of this patient population as more burdensome, challenging, difficult, and so forth. In another study conducted

by Drake and colleagues (2005), nurses voiced concerns about their personal safety when providing nursing care to PLWO, and feared that these concerns would negatively impact the quality of the care provided. To further complicate the issue, nurses also communicated concerns about the additional workload associated with providing care to this patient population in already strained clinical environments where resources are scarce, equipment and support is not always available, and staffing is insufficient (Drake, Dutton, Engelke, McAuliffe & Rose, 2005).

Building on these findings, the goal of the proposed study is to look specifically at the experiences of ICU nurses who work with PLWO in a fast-paced, stressful, demanding and highly technological environment, and how these experiences affect the way they provide care to this patient population. More specifically, it is designed to describe and explore the inclusionary and exclusionary practices (as defined by Canales, 2000 – see Chapter 3) developed by nurses providing care to PLWO. Thus far, the literature has focused primarily on exclusionary practices, but inclusionary practices have been researched to a much smaller scale. The dual nature of these practices requires further exploration, especially in the context of the ICU nursing care. Lastly, an additional goal of the study is to document the needs of ICU nurses with respect to the care of PLWO and areas of improvement in ICU.

## **1.2 Research Question**

The main research question for this project can be summarized as follows:

1. What are the experiences of ICU nurses working with PLWO?

## **1.3 Research Objectives**

The proposed study objectives include:

1. Describe the experiences of nurses working with PLWO in the ICU;
2. Explore how these experiences affect the way they provide care to PLWO;
3. Explore the practices or strategies developed to care for PLWO;

4. Identify the needs of ICU nurses with respect to the care of PLWO and areas of improvement in the ICU.

#### **1.4 Epistemological Position**

This research project is located within the critical theory paradigm as defined by Guba and Lincoln (1994, 2005) and draws on the theoretical framework of Canales (2000, 2010). From an ontological standpoint, the critical theory paradigm is concerned with the need to understand and study “reality” as a product of social, political, cultural, economic, ethnic and gender factors (Guba & Lincoln, 1994, 2005). It is also concerned with various structures, discourses, relationships, and arrangements that shape the way “reality” is understood and taken as “real” (Guba & Lincoln, 1994, 2005). From an epistemological standpoint, the critical theory paradigm is transactional and subjectivist (Guba & Lincoln, 1994, 2005). The researcher and the participants are assumed to be interactively linked, with the values of the researcher inevitably influencing the research process and the production of research findings (Guba & Lincoln, 1994, 2005). In this paradigm, research findings are closely linked to the epistemological position of the researcher, the personal and professional experiences of the researcher, the theoretical underpinnings of the research project, and contextual factors.

From a methodological standpoint, the critical theory paradigm is considered to be dialogic and dialectical (Guba & Lincoln, 1994, 2005). The research process requires a transaction or dialogue between the researcher and the participants (Guba & Lincoln, 1994, 2005). The dialogue, Guba and Lincoln (1994, 2005) explain, is paramount when attempting to uncover experiences and practices that are mediated by certain structures, discourses, relationships, and arrangements. Here dialogue is seen as a way to question, increase awareness, educate, and transform while interacting with participants (Guba & Lincoln, 1994, 2005). The role of researchers who engage in critical inquiry is to work towards some form of

transformation and to produce more nuanced ways of understanding issues of power, gender, discourses, ideologies, cultures, inequalities and so forth (Guba & Lincoln, 1994).

The critical theory paradigm is of particular importance for the proposed research project, and is compatible with the chosen theoretical framework. Nursing researchers who work within this paradigm understand the importance of situating nursing practice in context, including the clinical context, the institutional context, and the social context, to name a few (Mill, Allen & Morrow, 2001; Ray, 1992). This is relevant to this research project, because the experiences of ICU nurses working with obese patients cannot be separated from the context in which they occur. Structural, social and political influences (i.e., policies, discourses, protocols, routines, unit culture, etc.) need to be carefully considered in this research project, because they shape nursing practice and give rise to nursing practice issues (i.e., safety issues) (Mill et al., 2001; Ray, 1992). The critical theory paradigm allows nursing researchers to gain an in-depth understanding of these influences and to expose the way these influences manifest themselves in the personal accounts of individual nurses.

The critical theory paradigm assists nursing researchers in uncovering contentious practice issues and experiences that point to disparities in nursing care to achieve emancipation for individuals and groups (Mill et al., 2001). This is compatible with the theoretical framework of Canales (2000, 2010) and her analysis of Othering practices in nursing. (For a detailed description of the theoretical framework, see Chapter 3). Canales (2000, 2010) provides an ideal framework for looking at the way nurses work with patients who are viewed as “different” or Other. Yet, the framework and its’ application requires a thoughtful examination of the concept of power and the productive aspects of power in the nurse-patient relationship, i.e., how the use of power can produce disparities in nursing care (through exclusionary practices) or adapting nursing care to the special needs of patients through inclusionary practices (Canales,

2000, 2010). Drawing on critical theory, this research project attempts to conceptualize power in its' productive capabilities and to examine how power can be exercised through various forms of exclusionary and inclusionary nursing practices. As such, the main goal of this project is to clearly describe what is occurring in nursing practices with regards to the care provided to obese patients in the ICU as a way to increase awareness, educate, transform and bring attention to both exclusionary and inclusionary practices.

## CHAPTER 2

### LITERATURE REVIEW

This chapter will present the literature review in three sections. The first section will focus on the definition of obesity, the incidence and prevalence of obesity, and the description of what constitutes an “obesogenic” environment. The second section will introduce the social and medical constructions of obesity. Finally, the third section will provide a summary of the literature on the attitudes and perceptions of health care providers, with a particular emphasis on nurses and how nursing care can be impacted.

#### **2.1 Obesity: A Brief Definition**

Health care providers and researchers most commonly use the WHO definition of obesity. Obesity is defined as the “abnormal or excessive accumulation of body fat which may impair health” (WHO, 2012, p.1). Obesity in adults is determined through the use of the body mass index (BMI) (WHO, 2012). The BMI is calculated by a person’s weight in kilograms, which is then divided by his/her height in meters squared ( $\text{kg}/\text{m}^2$ ) (Health Canada, 2006; WHO, 2012). People who are identified as obese have a BMI of 30 or greater, and those who are considered morbidly obese have a BMI greater than 40, or are 100 lb. above their ideal body weight (Health Canada, 2006; Smith, 2008; WHO, 2012). The BMI is considered to be the standard measurement for defining obesity, yet many authors have noted that this measurement has a number of limitations (Wright, 1998) and was originally developed for use in population studies, not for individual diagnosis (Rail, 2012).

#### **2.2 Epidemiology**

In 2005, 800 million people were overweight, and 400 million people were identified as PLWO for having a BMI of  $30\text{kg}/\text{m}^2$  or greater (Rigby, Leach, Lobstein, Huxley & Kumanyika, 2009). It

has been found that one third of the 800 million people considered overweight reside in westernized countries (WHO, 2006). The number of PLWO is increasing in developing countries as well as in urban areas (Rigby et al., 2009). The WHO predicted that by the year 2015, this number would continue to increase to 2.3 billion overweight persons and 700 million PLWO around the world (WHO, 2006). Most countries, including the United States, Europe, the Middle East and Asia, have seen a consistent rise in the number of PLWO (Rigby et al., 2009). Factors that have been found to contribute to the global increase of PLWO included a Westernized lifestyle, increased food intake, high caloric food, and decreasing levels of physical activity (Rigby et al., 2009).

The prevalence of obesity in Canada is much lower than in the United States (Seidell, 2010; Torrance, Hooper & Reeder, 2002). Over the past decade, Canada has reported an increase in the numbers of PLWO, particularly men (Seidell, 2010; Torrance et al., 2002). A Canadian study described the increase in the prevalence of obesity from 9% in 1981 to 14% in 1996 in men, and the prevalence of obesity in women was slightly less, at 8% in 1981, increasing to 12% in 1996 (Tremblay et al., 2002). The prevalence of obesity varies between different ethnic and cultural groups; for example, the highest prevalence of obesity in Canada is documented among Aboriginal peoples (Kuhnlein, Receveur, Soneida & Egeland, 2004). The prevalence of obesity is a complex issue and is inversely related to the socio-economic status and the educational level of the individual and community (Rigby et al., 2009). This relationship is evident in that PLWO are among the least privileged and are often economically disadvantaged (Boero, 2009; Seidell, 2010).

### **2.3 The “Obesogenic” Environment**

To date, the literature has focused strongly on the PLWO responsibility for their excessive weight. Yet, lifestyle in Western societies has evolved over the years, and it now plays an

important role in the incidence of obesity. It has been suggested that today's society promotes obesity – that it is an “obesogenic” environment (Lupton, 2013; RNAO, 2005). An obesogenic environment is an environment that supports sedentary or inactive lifestyles as well as the intake of food with high fat and caloric content (RNAO, 2005; Speakman & Levitsky, 2008; Swinburn & Egger, 2010). Lupton (2013) defines an “obesogenic” environment as one in which obesity is facilitated by a number of societal factors. Swinburn, Egger and Raza (1999) defined an “obesogenic” environment as the sum of an individual's influences, including their surroundings, opportunities, or conditions of life that promote obesity in persons or communities. Obesogenic environments are shaped by physical environments (such as schools, neighbourhoods, available transportation, and home environments), advances in technology, and the transformation of the food industry as well as food products (Lupton, 2013; James & Gill, 2010; Swinburn & Egger, 2010). These environments are also influenced by the laws, policies, costs, social and cultural attitudes, and values of a community (Hill & Peters, 1998). Consequently, obesity should be approached from a social perspective and an individual perspective. Furthermore, the focus on PLWO's responsibility for their own weight needs to be de-emphasized to diminish the negative societal experiences that result. This would also be consistent with research suggesting that the causes of obesity have not been clearly and scientifically identified (Gard, 2011; Gard & Wright, 2005; Novak & Brownell, 2011; Sikorski et al., 2012) and that many environmental factors are at play in the rising incidence of obesity.

## **2.4 Social Construction of Obesity**

In and of itself, fat has no meaning. It is the specific historical, social and cultural context in which fatness is lived, experienced, portrayed and regulated which gives it meaning. These meanings are dynamic and shifting, and are subject to change as the context changes (Lupton, 2013, p. 3-4).

PLWO frequently experience negative societal perceptions and attitudes that result in unequal and diminished treatment in many aspects of their lives (e.g., work, school, health care, social

life, and so on) (Puhl & Heuer, 2009). PLWO are more likely to experience stigma and discrimination in Western societies due to the presence of negative attitudes, stereotypes, judgements and perceptions associated with obesity (Rogge, Greenwald & Golden, 2004). Other members of society, including health care providers (Pearl, Puhl & Brownell, 2012; Puhl & Heuer, 2009), may knowingly or unknowingly hold such attitudes and perceptions. The influence of societal context must be taken into account so that we can understand how obesity is perceived in Western societies, as well as how these perceptions affect the life and health experiences of PLWO. For example, other cultures and societies perceive obesity positively, and see a fat body as beautiful, indicating both good health and wealth, and as having a high social status (Sobal, 1999; Sobal & Stunkard, 1989).

A number of other terms refer to the same phenomenon of assigning reduced social value to PLWO. These include weight or obesity bias (Ip et al., 2013; Lieberman, Tybur & Latner, 2011; Pearl et al., 2012; Puhl & Heuer, 2009), anti-fat bias (Silverstein, 2010), obesity stigma (Brown & Thompson, 2007; Rogge et al., 2004; Texeira & Budd, 2010) and anti-fat attitudes (Brownell & Puhl, 2003; Puhl & Brownell, 2006; Teachman & Brownell, 2001; Zuzelo & Seminara, 2006). Lieberman and colleagues (2011) described weight bias as the negative attitudes and feelings people hold towards PLWO, which results in stigmatization. Anti-fat bias has been described as the negative attitudes and beliefs people have towards PLWO (Cramer & Stewart, 1998; Latner & Stunkard, 2003; Rand & Wright, 2000). These negative attitudes and beliefs are so pervasive that they have been observed in children as young as three years old (Meers, Koball, Oehlhof, Laurene & Mushur-Eizenman, 2011). Anti-fat bias can be viewed in weight-based teasing and social exclusion (Eisenberg, Neumark- Sztainer & Story, 2003; Strauss & Pollock, 2003). Texeira and Budd (2009) used Goffman's (1963) definition of stigma and applied it to PLWO to describe the consequence of explicit and implicit negative attitudes held towards obesity. Obesity stigma is the process by which PLWO are perceived as having a

discredited attribute that reduces their social status from a whole person to a discounted person. In other words, obesity stigma is the process of being viewed as discounted or of lesser value due to a physical difference (Goffman, 1963; Puhl & Brownell, 2006). Anti-fat attitudes result from prejudices and stereotypes people hold towards the members of PLWO (Mushur-Eizenman, Sholub, Hauser & Young, 2007). Pepper and Ruiz (2007) defined anti-fat attitudes as the belief that PLWO are responsible for their own weight. These terms differ, but all refer to society's negative views, attitudes, perceptions, judgements and stereotypes regarding PLWO, which may result in their vulnerability to social injustices and in unfair treatment, and, consequently, may impact their quality of life (Puhl & Heuer, 2009).

It has been suggested that much of society, including the health care system, is pre-occupied with preventing and containing obesity (Lupton, 2013). The maintenance of an ideal body weight has been promoted by the media and society as they spread the message that there is an urgent need to fight the obesity epidemic and address Western society's ever-increasing body size, thereby reinforcing the desirability of thinness (Lupton, 2013; Seale, 2002). The obesity epidemic has been presented as a threat to Western society, subsequently justifying the actions of government and society (Holmes, 2009). Holmes (2009) has proposed that the notion of an obesity epidemic creates large-scale social concern, which justifies and excuses actions, calls for solutions and feeds many levels of business and enterprise, including scientific and epidemiological research, medicine, public health, government and public industry. The perpetuation of the obesity epidemic as a population risk ensures that the responsibility of the obese persons' health is placed squarely within in their hands (Holmes, 2009). This has been furthered by the societal perception that obesity is associated with an individual's lack of self-control and willpower (Holmes, 2009; Wray & Deery, 2008).

Lupton (2013) believed that the weight of PLWO may overwhelm their “true selves,” including their identities and personalities (Lupton, 2013). At the end of the day, PLWO are no longer viewed as persons but as something else, something of a lesser value. This is consistent with the work of Goffman (1963) on stigma and of other authors who draw on his work in the field of psychology (Jones et al., 1984), sociology (Link & Phelan, 2001), and health sciences (Whitehead, Carlisle, Watkins & Mason, 2001). Researchers have observed that a stigma is malleable and affected by changes in society over time (Whitehead et al., 2001). The attitudes and beliefs of contemporary society continue to influence the meaning of a stigma as it is understood in terms of Western culture and social context (Whitehead et al., 2001). As a result of societal changes and world events, individuals in society reconsider, reflect, and re-evaluate what is considered important or of value to themselves and their communities (Whitehead et al., 2001). It is possible that, with the passage of time, society’s attitudes, beliefs and ideas associated with the PLWO will morph and change, and may no longer carry an inherent negative perception. These ideas and notions are compatible with Goffman’s understanding of stigmas and how an individual or group can emerge as socially different and experience being and feeling excluded, as well as the possibility that stigmatizing experiences can change over time (Goffman, 1963; Whitehead et al., 2001).

Many researchers within Western society believe that the underlying causes of the stigmatizing of and discrimination against PLWO are fostered by weight biases, anti-fat attitudes (Brownell & Puhl, 2003) and weight-based stereotypes (Pepper & Ruiz, 2007). These phenomena are a result of the fat-phobic society that we live in and of societal attitudes and perceptions that are often accepted without question or challenge (Lupton, 2013). The literature suggests that society’s negative attitudes towards this population are not only related to their physical appearance but also to personal behaviours, specifically, eating habits and sedentary lifestyles (Hill, 2008, Pepper & Ruiz, 2007, Shugart, 2011). Unfortunately, the focus on the

PLWO's personal behaviours results in the disregard of the impact of other societal factors, such as a lack of access to healthy foods for those PLWO who have low income (Kim & Willis, 2007; Lawrence, 2004; Saguy & Almeling, 2008; Shugart, 2011). These negative social attitudes give rise to stigma, and are intended to govern and contain the PLWO, bringing about their isolation, discrimination and marginalization in Western societies (Hill, 2008; Lupton, 2013). Similarly, the process of trying to govern the PLWO's body and behaviours occurs within the health care system when nurses judge patients to be in need of medical intervention and education to promote behavioural and physical change. The judgements made by health care providers are related to social attitudes as well as to the information promulgated by the medical system and public health institutions. Nurses are not exempt from having negative social attitudes perpetuated by these constructs that can unconsciously shape the PLWO–nurse relationship and nursing care.

The negative attitudes towards PLWO have been facilitated by television, mass media, newspapers, magazines and movies, putting forward the idea of thinness as healthy and attractive (Lupton, 2013; Wykes & Gunter, 2005). A study found that the media stigmatized PLWO in 72% of all the images of PLWO that were reviewed. This was determined through criteria that included pictures that emphasized the abdomen, that showed persons wearing ill-fitting clothes, pictures that did not show their heads, and pictures that depicted persons eating poorly or being sedentary (Heuer, McClure & Puhl, 2011). These depictions of PLWO are found in entertainment media such as fashion magazines, television shows, and movies. The entertainment media are identified as a primary source for reinforcing the negative and stigmatizing depictions of PLWO (Coulter, 1996; Greenberg, Eastin, Horshire, Lachlan & Brownell, 2003; Himes & Thompson, 2007; Sender & Sullivan, 2008). Gollust, Eboh and Barry (2012) believe that media representations of how different groups are affected by obesity could impact how the lay person thinks about obesity as a societal issue, and may influence their

beliefs about appropriate public policy responses. In addition, news coverage of the topic of obesity reflects and may reinforce public opinion and attitudes towards these persons (Bleich & Blendon, 2010). However, there is a way to counteract these events: People who were shown positive images of PLWO voiced more positive views of these persons than those who were shown negative photographs (McClure, Puhl & Heuer, 2011). The possibility that people's views of PLWO can be altered through changing the images and media surrounding this population presents a new opportunity for praxis and for changing social attitudes.

As previously discussed, the media (television, newspapers, magazines, the Internet and any and all sources) promote the ideal of the thin body and the grotesqueness of the obese body (Lupton, 2013). Through the media, obese bodies are presented as Others, who are perceived as "uncontained", "out of control" and "undisciplined" (Lupton, 2013). Conversely, the thin bodies are presented as "under control", "contained" and desirable (Lupton, 2013). The media presents the thin body as something to be aspired to as well as the "norm" (Lupton, 2013). According to Puhl and Heuer (2009), media promote the acceptance of weight stigma in Western culture. These negative societal ideals have become so pervasive that even persons who are not overweight find themselves struggling to control their food consumption and suffering from feelings of anxiety, guilt, shame and self-disgust as they try to conform to the "normal" societal standards of health and beauty (Jallinoja et al., 2007; Lupton, 1996; Lupton, 2013).

Consequences of these stigmatizing and discriminatory encounters can be experienced psychologically, socially and physically, and all are equally important and damaging to PLWO (Rogge et al., 2004). The lives of PLWO can be greatly affected by society's negative views, and they may experience social inequities (Puhl & Brownell, 2003; Puhl & Heuer, 2009; Rogge et al., 2004). For example, PLWO are less likely to be hired, have fewer opportunities for job advancement, are more likely to be fired than their non-obese coworkers (Puhl & Heuer, 2009)

and, consequently, they frequently have lower household incomes in comparison to those who are non-obese (Puhl & Brownell, 2001; Rogge et al., 2004). Brownell and Puhl (2003) point out that PLWO often face discriminating behaviours in other areas of their lives, specifically education and health care. Other social effects that may be encountered by these persons include diminished dating opportunities when they are perceived as undesirable due to body weight (Puhl & Heuer, 2009). Accordingly, men and women who live with obesity are less likely to be married or in a relationship (Rogge et al., 2004). Therefore, the negative societal attitudes can negatively influence the close personal relationships of PLWO (Puhl & Heuer, 2009). The personal relationships that can be affected include the romantic partners, family members and friends of the individual (Puhl & Heuer, 2009).

The internalization of societal stereotypes can be observed when the PLWO secretly agrees with society's negative stereotypes and stigma, and accepts that an "imperfect body represents an imperfect person" (Brownell & Puhl, 2003, p. 22). In other words, their physical size is considered to be a reflection of their personal character (Hill, 2008). The PLWO's internalization of societal stereotypes and stigma results in their agreement with the belief that their weight is of their own making and is a product of their poor lifestyle choices (Brownell & Puhl, 2003). PLWO rarely challenge or oppose society's beliefs that their excess weight is due to personal weakness, a lack of willpower and/or their own moral failure (Rogge et al., 2004). They may not challenge these beliefs due to feelings of self-blame, diminished self-worth and the internalization of the previously mentioned societal beliefs (Rogge et al., 2004). They may come to believe society's stereotypical views and attitudes so strongly that they regard other PLWO negatively. As a result, they may also believe that they deserve the unjust treatment they receive (Sikorski et al., 2012). This phenomenon presents the possibility that PLWO are not only stigmatized by others in society but also self-stigmatize due to the presence of pervasive negative and stereotypical views (Sikorski et al., 2012).

## 2.5 Medical Construction of Obesity

According to Lupton (2013), the power of medicine should be acknowledged as well as its role in constructing the definitions of which bodies are considered “normal” and “abnormal.” Medicine is also responsible for identifying which conditions and illnesses require medical attention and treatment (i.e., obesity and the need for surgical intervention) (Lupton, 2013). It has been argued that the medical apparatus has evolved into an agent of social control and governance relating to what society perceives to be acceptable weight and size (Wright, 1998). This has promoted the idea that health is associated with physical attractiveness and thinness (Lupton, 2013). Medicine and society in general have reinforced the perceived link of illness and disease with poor willpower and a lack of self-discipline (Lupton, 2013). They have also perpetuated the idea that there is a causal relationship between “inactivity, poor diet, obesity and poor health” (Rail, 2010, p.228). Due to these perceived links and relationships that society and medicine have constructed, PLWO become Others, “at risk” persons requiring discipline or punishment to control their body weight (Lupton, 2013). The universal rule that has been adopted and promoted is to “simply” “exercise more and eat less” (Rail, 2012, p.229), thus placing the onus on the individual person to follow this “simple” rule.

“Within medicine, obesity has come to be embraced as a disease” (Salant & Santry, 2006, p.2445). This has occurred due to a number of historical and social events that have led to the development of an etiology and therapeutic interventions associated with obesity, and have resulted in the medicalization of this condition (Sobal, 1995). Researchers have suggested that “obesity as a disease” has been put forth by those who would profit from its medicalization. This would include obesity scientists, bariatric surgeons, the fitness and weight loss industries, pharmaceutical companies and the health insurance industry (Campos, 2004; Gard & Wright, 2005; Oliver, 2005; Rail, 2012). In recent years, researchers have argued that the

medicalization of obesity has resulted from the distortion of statistics on increasing weights, the disregard of the complicated realities associated with having excess weight, the use of scarce resources and the distraction of those in the public health arenas (Brownell & Hogan, 2003; Campos, Saguy, Ernsberger & Oliver, 2006; Gaesser, 2006; Herrick, 2007; Rail, 2012). Rail (2012) observed that the BMI measurement assists in the arbitrary construction of what is obese, what is not obese, and what is healthy and unhealthy. To complicate the issue, this definition has changed over time, and different countries use the same BMI with different cut-off points. In 1998, the BMI cut-off point was lowered from 27.8 to 25 for persons who were defined as “overweight,” resulting in 25 million Americans, who were previously in the “healthy” category, being considered Other and “unhealthy” by medicine and society overnight (Lyons, 2009; Rail, 2012). Consequently, due to these changes, more people and groups were defined as obese and viewed as needing medical intervention and treatment by the dominant medical system (Rail, 2012).

In recent years, obesity has increasingly become conceptualized as illness in need of medical interventions (Jeffrey & Kitto, 2006). The medicalization of obesity has resulted in the view that PLWO require medical treatment (i.e., bariatric surgery), medical guidance to lose weight, and support to ensure that they are successful in their weight loss. From this perspective, those who are unsuccessful are often seen as non-compliant or not disciplined enough (Salant & Santry, 2006). On one hand, authors like Hofmann (2010) have argued that bariatric surgery can be used to promote health and beauty in PLWO. On the other hand, authors like Rail (2012) have wondered whether treatment and bariatric surgery is prescribed to PLWO as a means to “discipline and normalize bodies” (p.237) rather than to improve health. In fact, researchers have found that weight loss strategies alone can lead to PLWO experiencing negative health consequences such as weight cycling, eating disorders, poor body image and low self-esteem (Rail, 2012).

This raises concerns regarding the impact of promoting the importance of weight loss and medical interventions uncritically in health care. Nurses may feel pressure to adopt a biomedical view of obesity and to practice in a way that is predetermined by the biomedical model (Wray & Deery, 2008; Wright, 1998). For example, Wright (1998) has shown that nurses educate patients on weight control (often uncritically) and endorse the medical perspective of excess weight as a risk to health, despite the lack of any established, scientific causal link (Wright, 1998).

Many health care providers, including some nurses, believe that obesity is directly related to health problems, disease and illness (Rail, 2012). This link has been presented in a number of studies as if there is a direct and strong causal link between an elevated BMI and higher rates of morbidity and mortality (Gard & Wright, 2005; Lenz et al., 2009; Mark, 2005; Rail, 2012). However, this link is much more complicated and multifactorial, and it can be viewed in a number of ways. With the exception of persons having extreme BMI measurements, BMI has been shown to have little or no impact on morbidity and mortality, and adverse health effects of elevated BMI have been exaggerated in the literature (Rail, 2012). Despite preconceptions to the contrary, mortality rates in general, as well as mortality from coronary heart disease and stroke, have declined in recent years (National Center for Health Statistics, 2008; Rail, 2012). A number of researchers have argued that this issue is more complicated, and that this link does not reflect the influence of a person's socio-economic status, physical activity, weight cycling or use of diet drugs (Gaesser, 2003; Rail, 2012). The impact of these factors on a person's BMI has been ignored by medicine, media and society (Ernsberger, 2009; Rail, 2012).

The medicalization of obesity described above has been exacerbated by the "obesity epidemic," which the WHO has presented as threatening a global catastrophe (2000, 2011). The "obesity epidemic" has been used to instil fear and panic in the general public and the

medical system (Rail, 2012). Both PLWO and non-obese persons are encouraged to take steps to protect themselves against the “disease” due to the impending “obesity epidemic” (Rail, 2012). This process has resulted in an individual’s achievement and maintenance of a normal BMI being a civic duty as well as a personal responsibility (Rail, 2012). This occurs in a context of immense social pressure on PLWO, encouraging them to adapt and change to fit society’s “norms” (Rail, 2012). The medical system and physicians remain unchallenged, and they are authorized with the power to determine who is “sick” and who is “healthy” according to the size of a person’s body rather than the presence of illness (Rail, 2012). This same system preaches a message that weight loss is the answer and that it will improve health (Rail, 2012).

Research has noted that women have been the main target of the “obesity epidemic” campaign and of weight loss and cosmetic surgery industries (Boero, 2007; Rail, 2012). Gender and race were found to play important roles in this matter, because women, specifically women of colour, are more likely to live with being overweight or being obese, and they suffer from their Other label, from prejudice and from poor nutrition (Aphramor & Gingras, 2009). These researchers also found that the obesity scientists and experts are frequently lean, white males (Aphramor & Gingras, 2009). Women not only experience blame for obesity prevalence from public health institutions, they also face “mother blame” (Aphramor & Gingras, 2009). It is argued that women are becoming pregnant when they are overweight, gaining an excessive amount of weight during pregnancy and failing to lose the weight post pregnancy (Catalano, 2003; Murphy Paul, 2008; Reece, 2008; Symonds & Gardner, 2006). Poor women of colour are blamed as mothers who are passing poor eating habits on to their children, and are perpetuating unhealthy lifestyles (Boero, 2009).

## 2.6 Health Care Context

PLWO access health care services and will most likely require a hospital admission at some point in their lives. This patient population not only experiences value judgements from society and each other but also during encounters with health care providers (Falker & Sledge, 2011; Puhl & Heuer, 2009). Based on their weight, PLWO may experience harm and insensitivity due to stigma and oppression related to health care providers' perceptions of PLWO as being "unattractive", "less worthy" or "inferior" (Rogge et al., 2004; Wray & Deery, 2008), "lacking self-control" and "being lazy" (Brownell & Puhl, 2003). Health care providers have been shown to view obesity as the representation of a flawed character, and they link a PLWO's failure to lose weight to a lack of discipline or compliance with medical advice and treatment (Brownell & Puhl, 2003; Puhl & Brownell, 2001). Society's negative attitudes are so pervasive that even health care providers who are dedicated to providing compassionate and non-judgmental care and treatment are unaware that they attach negative attitudes to PLWO (Brownell & Puhl, 2003). More research related to this topic would help to increase awareness of the work challenges that providers encounter, as well as providing insight into whether these challenges affect health care providers' attitudes and perceptions of this population.

Brownell and Puhl (2003) emphasized the need for health care providers to pay attention and to be mindful of the small and large ways that weight bias presents itself. Weight bias can present as too-small waiting room chairs and treatment gowns, or as caregivers who have negative or ambivalent attitudes during interactions with these patients (Brownell & Puhl, 2003). Health care providers, including nurses, need to be aware of the PLWO's fear of being weighed and criticized within the health care setting (Brownell & Puhl, 2003). It should also be noted that not all illnesses and conditions that PLWO experience are caused by their excess weight (Aramburu, Drury & Louis, 2002). Their feelings of fear and shame and their experience of

criticism for their weight by health care providers can result in their reluctance to obtain medical treatment and in their avoidance of preventative health care (Aramburu et al., 2002; Brownell & Puhl, 2003; Vacek, 2007). Nurses and other health care providers must be conscious of patients' feelings of fear and of being criticized, because their attitudes and perceptions can affect their ability to communicate with PLWO (Brown & Thompson, 2007). A nurse's ability to communicate may be affected further by feelings of awkwardness and discomfort (Brown & Thompson, 2007). These feelings may result in nurses avoiding the discussion of sensitive subjects, such as a patient's body size and its effects on their health status (Brown & Thompson, 2007). At the same time, the nursing population is predominantly female, and they can also experience social pressures to be thin. These experiences may increase awareness and sensitivity to comments made to those who are perceived as "overweight" or "obese" (Wright, 1998). If a PLWO encounters damaging social experiences within the health care setting, these patients may avoid accessing health care services for preventative treatment (Vacek, 2007) and for prenatal care (Aramburu et al., 2002).

Pokorny and colleagues (2009) conducted a research study that identified the challenges that home health care and hospice staff encountered while caring for PLWO. Nurses reported that PLWO were highly dependent, and that a majority of them could not perform activities independently and required assistance (Pokorny et al., 2009). This perception of patient dependency often resulted in patient and caregiver fatigue (Pokorny et al., 2009). Nurses voiced physical challenges associated with providing care during bathing, toileting, dressing, walking and getting out of bed; these included reaching the skin folds, managing a 150 lb. apron of flesh (panniculus), difficulty turning and properly cleaning all areas, as well as difficulties lifting the patient's legs (Pokorny et al. 2009). These findings were noted in homecare and acute care settings, and are consistent with other studies undertaken with nurses in acute care settings (Pokorny et al., 2009). For example, nurses assigned to PLWO must be

mindful of maintaining the patients' skin (Pokorny et al., 2009). Skin challenges that are faced by a number of PLWO include yeast infections or wounds in the skin folds (Pokorny et al., 2009). In an acute care setting, PLWO are often too sick to get out of bed, which may also be the case in their home settings; this can result in high demands on nursing staff (Pokorny et al., 2009). All of these situations present a number of difficulties and challenges for nursing staff, not only in home care but also in intensive care settings.

## **2.7 Providing Nursing Care to PLWO**

Nurses face a number of obstacles and challenges while trying to provide nursing and medical care to PLWO in an intensive care setting. Patient care in a hospital setting can be extremely complicated; it requires a higher level of organization due to the need to group tasks, because more individuals are needed to assist to complete the tasks. For example, Drake and colleagues (2005) suggested that nurses from medical-surgical intermediate care, labour and delivery room and rehabilitation felt PLWO who were more acutely ill were more challenging. These concerns are not unfounded. PLWO in ICU are considered more challenging because of the increased difficulty associated with providing physical care, such as turning and mobility, due to the patient's inability to assist with nursing tasks (Drake et al., 2005, Martino et al., 2011). The same researchers found that nurses feared for their personal safety when providing nursing care to PLWO, and feared that the nursing care provided to these patients could be negatively affected (Drake et al., 2005). This was compatible with the findings of Pokorny and colleagues (2009). Research has also shown that nurses were concerned with the additional workload, inadequate staffing levels, and the increased time required to care for PLWO and their needs for specialized nursing and medical care in already stressed clinical environments (Drake et al., 2005; Whitefield & Grassley, 2008; Zuzelo & Seminara, 2006).

The ICU is a highly technical, intense and acute clinical environment, and little or no research related to this environment and PLWO has been undertaken. There is also a lack of research related to the experiences of nurses who care for this patient population in the ICU setting. Obesity affects a nurse's ability to provide high quality patient care, and affects nurse-patient interactions as well. Davidson and Callery (2001) stated that all PLWO who are admitted to the ICU are classified as highly acute in comparison to non-obese ICU patients, because procedures that are usually considered routine require more time and effort to complete. For example, procedures such as inserting intravenous access, providing personal care, inspecting, assessing and repositioning of the patient all required more effort and more staff to assist (Davidson & Callery, 2001). The literature also stresses the need for the patient to have frequent turns and to achieve early ambulation, which may require more health care providers and equipment for PLWO than for non-obese patients (Davidson & Callery, 2001). It must also be remembered that, if these patients are in any way unstable, the likelihood of the nursing staff to be able to turn them safely is decreased. El-Solh et al. (2000) concluded that critically ill patients living with morbid obesity, compared to their normal weight counterparts, were at an increased risk for morbidity and mortality due to factors such as organ dysfunction and long-term complications during ICU stays. Consequently, Martino et al. (2011) observed that this population often experiences longer ICU and hospital stays.

The patient's weight can affect their ability to have necessary diagnostic testing completed, including CT scans, MRI's, x-rays, angiography and nuclear medicine tests (Davidson & Callery, 2001). Many of the diagnostic machines have weight limits between 350 to 500 lb. (Davidson & Callery, 2001; Martino et al., 2011), resulting in limited diagnostic and treatment options. Ultimately, these patients may be incorrectly or incompletely treated due to the medical team's inability to diagnose the illness or condition (Davidson & Callery, 2001). PLWO in the ICU also require special beds and lifts to prevent pressure ulcers and to make

repositioning and turns easier (Davidson & Callery, 2001). There are a number of equipment difficulties faced by ICU staff, not only with repositioning and turns but also with transferring patients to a toilet (Davidson & Callery, 2001). For instance, many of the hospital toilets can only be used, without risk of injury or breaking the fixture, by individuals under or equal to 300 lb. (Davidson & Callery, 2001). Davidson and Callery (2001) found that there are also safety issues for nurses who repeatedly care for immobile PLWO; nurses who are required to assess, turn and transport these patients are at an increased risk for physical injuries, and caring for the immobile PLWO poses a risk to the nurse's safety. It was speculated that the risk may be even greater due to the increasing average age of ICU nurses, which, in 2001, was greater than 45 years of age in the United States (Davidson & Callery, 2001).

## **2.8 Attitudes and Perceptions of Nurses**

It has been established that nurses hold negative attitudes and perceptions of PLWO, but the degree and extent to which these attitudes are held is affected by a number of personal factors. While the research conclusions were inconsistent, nurses' attitudes and perceptions were found to be impacted by such characteristics as the level of their professional education, their age, weight and clinical experience (Bagley et al., 1989; Brown, 2006; Culbertson & Smolen, 2011). To clarify the point, older nurses with more professional education and younger nurses who had less experience held more positive attitudes towards their PLWO (Culbertson & Smolen, 2011). The research found that nurses who were unhappy with their own body weight and size often viewed their PLWO more negatively (Brown & Thompson, 2007; Culbertson & Smolen, 2011). In contradiction, Brown, Stride, Psarou, Brewins and Thompson (2007) found that negative views of PLWO were only related to health care providers' own BMI's and not to their level of previous clinical experience, occupation, age or gender. However, the attitudes of male nurses with low to normal BMI's in Poon and Tarrant's (2009) study were more negative, indicating that

gender roles may be a factor in the attitudes and perceptions nurses hold towards PLWO. On the other hand, Hoppe and Ogden (1997) found that, although some nurses had higher BMI's and experienced stigma themselves, they still held negative attitudes towards the PLWO. Yet, these nurses also empathized with the PLWO. Nurses who live with obesity often felt that they were ineffective role models and were unable to instruct their patients on how to make healthy lifestyle choices (Brown & Thompson, 2007). The same study revealed that nurses who had a low BMI experienced difficulty communicating with their PLWO and voiced feelings of awkwardness (Brown & Thompson, 2007).

Nurses who were faced with frustration and challenges while providing physical nursing care to a PLWO "*often reacted in a way that challenged the overall philosophy of the nursing profession*" (Peternelj-Taylor, 1989, p. 751 [emphasis added]). Many nurses acquired society's learned stereotypes and biases towards PLWO, and these stereotypes and attitudes were underpinned by their beliefs related to the physical health consequences of living with obesity (Brown, 2006). These nurses were found to have a wide range of concerns, ideas and feelings related to obesity. These included concerns about the health consequences of obesity, feelings of disgust towards PLWO, ideas that obesity is associated with laziness, poor willpower, and weak personality, as well as obesity being a matter of personal responsibility (Brown, 2006; Brown et al., 2007; Puhl & Heuer, 2009; Vacek, 2007). Society's views of PLWO are so pervasive that nurses may think of these persons in a number of ways: as "unattractive" (Peternelj-Taylor, 1989), as "having a low-intellect" and as "gluttonous" (Vacek, 2007). Nurses have also described their experiences of caring for PLWO as "uncomfortable", "stressful", "repulsive" and "disgusting" (Poon & Tarrant, 2009, Vacek, 2007). These beliefs were present despite the nurses' understanding of the important role that the PLWO's family history played in the patient's physical weight and health (Brown et al., 2007).

Society, nurses and other health care providers believe obesity is preventable and treatable, and they positively view the health benefits associated with weight loss (Ogden & Hoppe, 1998). Nurses perceived PLWO's non-compliance with advice as a primary cause of their failure to lose weight (Ogden & Hoppe, 1998). Jallinoja and colleagues (2007) found that 88% of physicians and 95% of the Scandinavian nurses they studied agreed that patients must accept responsibility for their weight loss and lifestyle decisions. These nurses thought that a patient's resistance to change is almost always a barrier to their weight loss treatment (Jallinoja et al., 2007). The negative judgments held by health care providers coincided with their beliefs that PLWO lack willingness to alter their lifestyle and eating habits, as well as responsibility for their own weight loss (Jallinoja et al., 2007). These judgments and beliefs may be unrealistic or idealistic, and do not take into account other factors that may influence a person's weight (Jallinoja et al., 2007).

There was an overarching belief among health care providers that the causes of obesity were within the PLWO's personal control, for instance, their caloric intake and physical activity (Lupton, 2013; Poon & Tarrant, 2009; Sikorski et al., 2012). It has been suggested that the attribution of obesity to personal control may be the foundation of weight stigma (Sikorski et al., 2012). Many nurses believed that obesity was preventable, and these beliefs led them to view PLWO as lacking control over their weight and lacking motivation to change (Brown, 2006; Brown et al., 2007). No matter which clinical environment the nurses worked in, they felt that PLWO should be placed on diets during hospitalization (Poon & Tarrant, 2009). Nurses' underlying attitudes toward the PLWO as being self-indulgent perpetuated their views of PLWO as "demanding", "dependent" (Brown, 2006; Reto, 1989), and "isolated" or "depressed" with feelings of helplessness (Drake et al., 2005). These patients were also viewed as being "hoggish," "lazy," "unfriendly," "dull," "slothful," "inappropriate" and "dumb" by providers (Sikorski et al., 2012). PLWO were thought to have unrealistic expectations related to nursing care and

outcomes (Drake et al., 2005; Gurjral, Tea & Sheridan, 2011). These negative attitudes and beliefs were noted in many nurses across services and specialties (Gurjral et al., 2011). The positive attributes that were associated with obesity in one study were stereotypical ideals only, and described PLWO as funny, happy and cuddly (Sikorski et al., 2012).

## **2.9 Impact of Experience on Attitudes and Perceptions of Nurses**

The impact of nursing experience cannot be ignored as a factor when discussing nurses' perceptions of PLWO, although there have been conflicting findings in the research. For example, Poon and Tarrant (2009) and Bagley et al. (1989) noted that registered nurses held more negative perceptions towards PLWO than nursing students did. These perceptions and attitudes may be influenced by a lack of environmental resources, equipment and facilities to safely provide care for patients (Schmied, Duff, Dahlen, Mills & Kolt, 2011). Nurses' previous experiences with PLWO may stimulate feelings of powerlessness, inadequacy and loss of control, which are caused by the physical difficulties nurses face when providing care (Reto, 2003). These past experiences may affect the future care of the PLWO, and nurses may be unaware of these consequences (Reto, 2003).

It is also possible that health care providers are not automatically labelling these persons and desensitizing themselves to the needs of this patient population (Falker and Sledge, 2011). Jeffrey and Kitto (2006) focused on the perceptions and experiences of nurses who cared for PLWO who had undergone bariatric surgery. The nurses' perceptions of these persons were not static, but fluctuated between judging them as responsible and irresponsible (Jeffrey & Kitto, 2006). The judgments on behalf of the nurses are further solidified by society's and nurses' beliefs that an individual who is in control and disciplined should not seek medical assistance and should be aware of the consequences of living with obesity and needing bariatric surgery (Jeffrey & Kitto, 2006).

Work environments and other contextual factors may affect nurses' attitudes and perceptions of caring for PLWO. For example, nurses may be impacted by fears and previous nursing experiences. In a number of studies, many nurses voiced feelings of fear that they or their patient might suffer a physical injury while providing physical care to the PLWO (Arzouman et al., 2006; Pokorny et al., 2009; Whitfield & Grassley, 2008; Zuzelo & Seminara, 2006). These nurses feared that their safety might be compromised due to a lack of available equipment and supports (Pokorny et al., 2009). Nurses are challenged further to prevent personal injury and to protect their patients from injuries during the provision of physical care (Zuzelo, 2005). Consequently, nurses may develop feelings of inadequacy and loss of control due to the overwhelming physical and emotional demands of caring for PLWO (Brown, 2006; Culbertson & Smolen, 2011; Zuzelo & Seminara, 2004), as well as the demands of an increased workload (Drake et al., 2005). The researcher found a significant correlation between nurses' negative views of PLWO and negative views of caring for these patients, and it showed that, if given an option, many nurses would prefer not to care for a PLWO (Bagley et al., 1989; Culbertson & Smolen, 2011). This fear of physical injury may be exacerbated by the increasing age of the nursing population, as physical aging may inadvertently increase their risk of injuries while providing patient care (Arzouman et al., 2006). It should be noted that much of the literature reviewed highlighted the negative feelings, attitudes and experiences nurses reported with PLWO, and only presents one side of the possible experience and outcome.

To date, the literature has focused solely on the negative attitudes and perceptions that PLWO encounter. Researchers also need to focus on nurses' positive experiences with PLWO, and on how nurses foster inclusion and equality in nurse-patient interactions. Only a small number of studies have observed that nurses can experience positive as well as negative attitudes and perceptions about the PLWO. In addition, these positive experiences should not be discounted but explored through the pursuit of further research on this aspect of the PLWO's

patient experience. The duality and complexity of the situation were noted by Schmied and researchers (2011), who observed that Australian midwives and maternity nurses noted an increasing acceptance of PLWO as well as a continued stigma associated with the condition. It was also recognized that nurses had generally positive attitudes towards these patients (Zuzelo & Seminara, 2006). Furthermore, nurses were conscientious and tried to give this population the utmost respect during nursing care (Zuzelo & Seminara, 2006).

Zuzelo and Seminara (2006) found that nurses believed that PLWO deserved equal treatment, recognized that this population has unique nursing needs and stated feelings of being “astounded”, “sympathetic” and “overwhelmed” by their care needs. Nurses made an effort to avoid hurtful encounters, dreaded physical care demands, and, finally, worried about their personal safety and the safety of the patient (Zuzelo & Seminara, 2006). In other words, the nurses in this study held positive attitudes and emotional responses towards PLWO even though they continued to cope with the realities of PLWO care demands and safety concerns for both the patient and themselves (Zuzelo & Seminara, 2006). The nurses sampled for this study came from three settings: a medical centre, an acute rehabilitation facility and a nursing facility (Zuzelo & Seminara, 2006). This study found no statistical correlation between nurses’ attitude scores and self-reported body weight, years of experience, level of education and type of work setting (Zuzelo & Seminara, 2006). Findings in the previously cited study by Sikorski et al. (2012) reinforced the notion that nurses’ perceptions can change, and showed that a closer relationship between a PLWO and a health care professional resulted in a less negative view of the patient.

A study conducted by Whitfield and Grassley (2008) on the experience of surgical unit nurses with post-operative PLWO described the nurses’ lived experiences caring for this patient population, as well as describing the underlying power issues that can occur within nurse-

patient relationships and their influence on nurse attitudes (Whitfield & Grassley, 2008). The researchers had anticipated that the participating nurses would have expressed prejudicial views of caring for PLWO; yet, the majority of the nurses voiced mostly positive, empathic attitudes towards caring for this patient population (Whitfield & Grassley, 2008). The research findings suggested that the positive attitudes that nurses held towards PLWO indicated that not all nurses avoided or disliked caring for this group of individuals (Whitfield & Grassley, 2008). The researchers also stressed that nurses can change their perspectives about caring for PLWO once they become better acquainted with the person (Whitfield & Grassley, 2008). Ultimately, these findings suggest that getting to know a PLWO may diminish or remove negative attitudes and stereotypes, because the patient is then viewed holistically and as a unique person rather than as a PLWO.

The majority of literature published thus far is primarily focused on nurses' negative attitudes and perceptions of PLWO. However, it should be remembered that these nurses' attitudes and perceptions can be positive, neutral or mixed, and can fluctuate, depending on the situational context (Brown, 2006; Whitefield & Grassley, 2008). In reality, nurses hold and experience a combination of positive and negative attitudes towards this patient population. An exploration of their whole experience would provide a more complex, in-depth and detailed insight into how intensive care nurses work with PLWO. It is also worth pointing out that not one research study focused only on nurses within the intensive care environment, although these patients are considered more unstable, challenging and difficult to provide basic nursing care to due to their illness and/or physical size. The contextual, clinical and personal challenges nurses face when caring for these patients may promote negative feelings towards this patient population, which could conflict with their nursing philosophy and their desire to provide high quality patient care without judgment. Such factors deserve additional attention.

## CHAPTER 3

### THEORETICAL FRAMEWORK

There are a number of different ways of conceptualizing and theorizing Othering. However, this study is based solely on the theoretical framework of Canales (2000), who theorized Othering in the context of nursing practice. The first section of the chapter provides a background on Othering, and draws on the literature from sociology. The second section introduces the theoretical framework of Canales. Finally, the third section of the chapter provides an overview of how the framework has been applied within nursing research to date and why it has been chosen for the purpose of this study.

#### 3.1 Background

The concept of Othering had been presented and applied in a wide variety of fields including post-colonial studies, sociological studies, critical theory, feminist studies, educational and cultural studies (Canales, 2000). However, the concept is fairly new in nursing, and it has only recently been introduced to nursing scholarship and research by Canales. Othering is rooted in symbolic interactionism, and its evolution has been influenced by a number of other concepts, including the concept of stigma (Canales, 2000). In order to comprehend Canales' work, it is important to provide a brief overview of the theoretical underpinnings of symbolic interactionism and a brief overview of the concept of stigma.

##### 3.1.1 Symbolic Interactionism

Symbolic interactionism is largely based on the work of Herbert Blumer (1969), who defined the term according to three premises: "Human beings act toward things on the basis of the meanings that the things have for them...; the meanings of such things are derived from, or arise out of, the social interaction...; and the meanings are handled in and modified through an

interpretive process used by the person in dealing with the things he encounters ...” (p.2). According to Blumer (1969), “society consists of individuals interacting with one another” (p.7) and cannot be studied without first taking into account these interactions. These interactions, explained Blumer (1969), are determined in a number of different ways. The way individuals interact and engage with each other can be determined by themselves, by a group of individuals, or by their culture and the social structures present in their lives (Blumer, 1969). Blumer (1969) considered that all members of society live their lives as ongoing processes that reflect how they interact together (predominantly on a symbolic level) during the activities of their daily lives. He argued that the ways in which members of a society interact together can provide insight into how society is structured and organized (Blumer, 1969). In his work, Blumer (1969) made an important observation, namely, that each individual has a “makeup” or appearance that does not deviate from the rest of society and acts as a defining feature. In other words, each individual comes to be defined by other members of society based on their appearance and actions during social interaction (Blumer, 1969). Blumer (1969) believed that we begin to see and identify ourselves similarly to how others think of us (Blumer, 1969). This process of identifying “self” and “Other” during social interactions is fundamental to the Othering framework.

### **3.1.2 Stigma**

Understanding the conceptual ties between stigma and Othering provides understanding and insight into the theoretical underpinnings of Canales’ work. This section draws on the work of Erving Goffman, who is known for his essay on stigma and the management of social interactions. Goffman (1963) defined stigma as the way in which a person is “marked” as different (or Other) during social interaction. Stigma is best understood as a relationship between a particular characteristic and a stereotype (Goffman, 1963). In fact, stigma is the

product of a derogatory identification process through which a person who possesses certain physical traits, displays specific behaviours or belongs to a social group is situated outside the regulatory framework of a society. As such, it is important to understand that anyone who does not conform to a set of established social norms could be considered as stigmatized (or Other) and, as a result, could experience status loss and discrimination. As such, persons who are identified as different (or Others) frequently encounter the “Us”-and-“Them” divide (Peternelj-Taylor, 2004). This divide is based on the identification of specific physical traits (disabilities, deformities, obesity, scarring, amputations, skin colour, etc.), behaviours, conditions or other means of identification (mental illness, homosexuality, alcoholism, addiction, unemployment, criminal behaviours, promiscuity, etc.), and group affiliation (ethnicity, religious beliefs, nationality, etc.) (Goffman, 1963) that are socially constructed as negative, problematic, unhealthy, undesirable, and so forth. This divide is important to consider, because it serves as a foundation to Othering practices that Canales describes in her work. As such, the outcomes of being stigmatized or being labeled as Other share many commonalities. These outcomes include, but are not limited to, decreased overall health, well-being and quality of life; challenges with respect to treatment, care, and support; diminished financial and social opportunities; and overall disparities (Johnson et al., 2004).

### **3.2 Othering: The Framework**

Canales (2000) developed a theoretical framework on Othering for analyzing nurses' engagement with the Other in clinical practice. Here, the Other was defined as a person (e.g., patient, nurse, co-worker, family member) who is viewed as different from one's self (Canales, 2000). Canales' framework described two distinct sets of practices that are used by nurses when they interact with the Other: exclusionary practices and inclusionary practices. These practices will be described in more detail in the following sections. One of the main goals of this

framework was to clarify how power within the relationship can be used in exclusionary and inclusionary ways (Canales, 2000). Another goal was to describe how certain practices impact those who are identified as Others, who are treated differently, and who sometimes are excluded from the health care system and society as a whole (Canales, 2000). The framework provides guidance for nurses to attend to the overarching conditions and structures that create and maintain the “vulnerable” status of the Other (Canales, 2000). It also provides the conceptual insights for nurses to understand, describe, explore, examine, and question how they engage and interact with the Other in clinical practice (Canales, 2000).

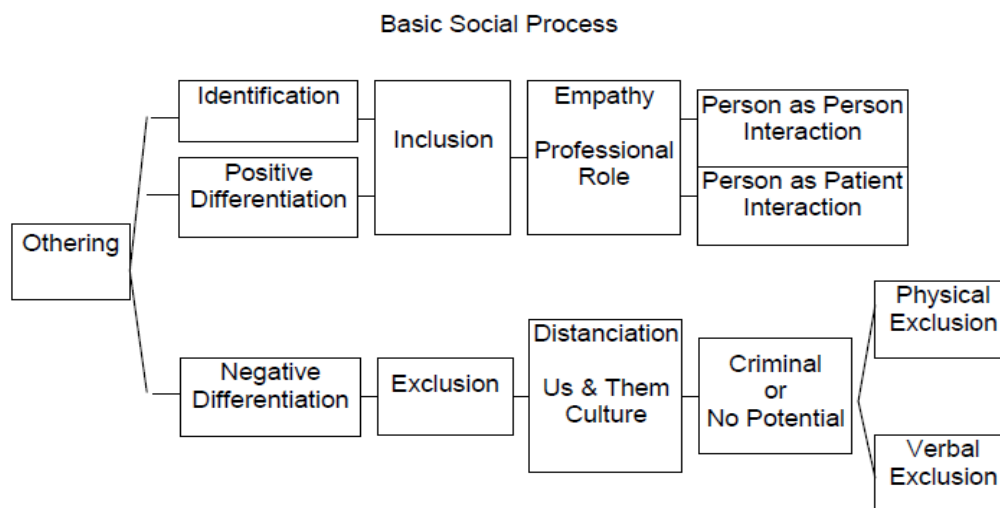
### **3.2.1 Othering Practices**

Canales (2000) described two distinct sets of Othering practices. Exclusionary practices use the power in the relationship to differentiate, to exclude, to neglect, and to oppress the Other (Canales, 2000). By way of contrast, inclusionary practices use the power in the relationship to build a sense of connectedness, to include, to transform, and to foster stronger social ties with the Other (Canales, 2000). These categories were established to assist in identifying practices that positively or negatively impact relationships with patients, nurses, co-workers, and family members who are considered different from one’s self (Canales, 2000). However, it must be noted that, although Othering is composed of dual practices, these practices are not mutually exclusive (Canales, 2000). Exclusionary and inclusionary practices are complex; they can manifest in various ways based on personal factors, past experiences, social interactions, context, and so on (Canales, 2000). Furthermore, it is important to emphasize that these practices are not fixed. As such, the same person may experience exclusionary Othering in one situation and experience inclusionary Othering in another situation (Canales, 2000; MacCallum, 2002). Canales (2000) explains that “the differences that separate us often shift with time, distance and perspective” (p.16). Consequently, being identified as Other may also be a

temporary or transient experience for many people who come into contact with the health care system. For instance, MacCallum (2002) found that persons with mental illness can move in and out of their status as Others based on the situation, the context, the time, and the interactions.

Building on his work in the field of forensic psychiatric nursing, Jacob (2010) explains that nurses can either identify with patients or differentiate themselves from their patients depending on personal characteristics, past experiences, patient history, and context. These factors may challenge the ability of the nurse to identify with the patient and may allow for a differentiation process to take place (Jacob, 2010).

**Figure 1.** Identification and differentiation as defined by Jacob (2010, p.199).



When the patient is identified as sick, unwell, and in need of medical attention, the nurse can identify with the behaviours, the interactions, and the attitudes of the patient as manifestations of an illness (Jacob, 2010). When the same patient is seen as manipulative, dangerous, deviant, or disgusting, a negative differentiation occurs. The behaviours, interactions, and the attitudes of the patient may then be viewed as unacceptable and problematic, and may result in social distancing (Jacob, 2010). Identification (inclusionary) and

differentiation (exclusionary) processes are thought of as fluid, and the nurse may move in and out of the processes depending on the context of the situation and the nurse's level of experience (Jacob, 2010). These processes are intertwined with the process of labeling the Other and society's tendency to Other those persons identified as "different."

### **3.2.2 Inclusionary Practices**

The inclusionary practices as defined by Canales' (2000) attempt to "use power to create transformative relationships in which the consequences are consciousness raising, sense of community, shared power, and inclusion" (p.25). In other words, these practices can be used by nurses to engage with the Other in a way that is inclusive and transformative (Canales, 2000). These practices include, but are not limited to, (a) role taking, (b) reconceptualizing meanings and understandings, and (c) connecting as allies (Canales, 2000).

*Role taking* has been influential in Canales' (2010) work on inclusionary practices and is often described as a way to "connect through difference" (p.24). Role taking is said to occur when nurses "take the role of the Other, however that Other is defined, and begin to see the world from the Other's perspective" (Canales, 2000, p.25). Here is a strategic attempt to view a situation or experience from another standpoint — one that takes into account the difference of the Other in a productive (positive) way. Canales (2000) argues that role taking is imperative if nurses want to connect with the Other as allies, to gain a better understanding of issues that are relevant for people who may think, look, and act differently, and to raise awareness on specific issues and disparities that are experienced by people who are believed to be different. Role taking is achieved through the use of imagination, informed empathy, and insight (Canales, 2010). As such, nurses can use these strategies to gain a better understanding of situational, contextual, economic, sociopolitical, structural, and environmental conditions that impact the Other (Canales, 2010).

In the nursing literature, inclusionary practices have become synonymous with role taking (Canales, 2010). Canales noted this in 2010 when she published the findings of a literature review on Othering. She also noted that other inclusionary practices, namely, reconceptualizing meanings and understandings, and connecting as allies, have not been used to their full potentials within nursing research (Canales, 2010). *Reconceptualizing meanings and understandings* of difference requires that nurses question why certain individuals, groups or communities are identified as different, explore how difference plays a role in the construction of the Other, and challenge how difference is used and for what purposes (Canales, 2000). Rather than conceptualizing difference as an issue, a barrier, and a negative attribute, nurses can approach situations with the specific objective of exploring new ways of understanding as well as exploring new opportunities for critiquing existing structures, empowering and connecting during therapeutic interactions, and moving away from stereotypical representations of the Other (Canales, 2000). Nurses can also *connect as allies* to challenge the idea that difference should be understood “in terms of separation, to divide and conquer” (Canales, 2000, p.26).

### **3.2.3 Exclusionary Practices**

Within the nursing literature, exclusionary practices appear to be referenced and researched more often than the inclusionary practices (Canales, 2010). Exclusionary practices mobilize power in ways that create oppressive relationships in which the consequences are “alienation, marginalization, decreased opportunities, internalized oppression, and exclusion” (Canales, 2010, p.19). These practices include, but are not limited to, (a) failing to role take or failed role taking, (b) stereotyping, and (c) essentializing (Canales, 2000; Johnson et al., 2004).

*Failing to take the role* of the Other or *failed role taking* can lead to situations where nurses are unable to see the world differently, to see it from the perspective of Other individuals, groups, and communities (Canales, 2000). This limits the ability of nurses to effectively engage

in meaningful dialogue about issues, hardships, and conditions that are specific to the social location of the Other (Canales, 2000). Furthermore, this limits the ability of nurses to move past misconceptions and stereotypes during social interactions (Canales, 2010). Canales (2000) describes *stereotyping* as another important exclusionary practice. She states that “stereotypes dramatize separation: separating between, within, and across races, classes, genders, cultures, and histories” (p.22). This separation results in nurses disengaging from those who are different, failing to relate to the Other, and, therefore, failing to role take (Canales, 2000). Canales (2000) explains that “without role-taking opportunities, or with resistance to these opportunities, [nurses] often fail to gain an understanding of the meaning others attribute to their world” (p.22). In turn, this can have important consequences on access to treatment and care, health care provision, and health outcomes (Johnson et al., 2004).

Canales argues that visibility of one’s Otherness is an important factor to consider with respect to stereotyping. Individual characteristics such as skin colour, ethnicity, language, physical ability, weight and size, gender, age, and appearance can contribute to making differences more visible in social interactions (Canales, 2000). These characteristics are also important to consider when looking more specifically at other practices such as *essentializing*. This practice draws on the work of Johnson and colleagues (2004), who described how noticeable differences such as ethnicity and language could lead to “overgeneralizations about things such as culture, race, location, social background, and health care practices” (p.260). These overgeneralizations “tend to be (...) abstracted from the broader social, [cultural], economic, and political issues influencing health, health practices, and ways of life more generally” (Johnson et al., 2004, p.260). The use of essentializing explanations, for example, is common in health care settings to create binaries between Us (nurses) and Them (patients and families), good and bad (patients, behaviours, choices, practices, and so on), and appropriate or inappropriate (decisions, priorities, needs, actions, and so on) (Johnson et al., 2004).

There are a number of negative consequences associated with exclusionary practices. The impact of these practices on health disparities and inequities can be seen at individual, population, and societal levels (Canales, 2000; Chan, 2009; Johnson et al., 2004; Peternelj-Taylor, 2004). These include, but are not limited to, shorter life expectancies, higher mortality rates, higher burden of disease, and overall diminished physical and mental health outcomes (Johnson et al., 2004). The use of exclusionary practices in the context of health care may also deter certain groups of people from accessing public health services and primary health care, and deter them from remaining in care (prenatal follow-ups, medical follow-ups, etc.) and from seeking medical attention when needed (e.g., medical emergencies, new symptoms, etc.), which may contribute to diminishing their health status altogether (Johnson et al., 2004; Peternelj-Taylor, 2004; Puhl & Heuer, 2009). These barriers occur as a result of their feeling unwelcome and unwanted in health care settings (Johnson et al., 2004). Furthermore, some groups may face structural and social barriers that reduce their opportunities to access care, treatment, and support for existing conditions (Johnson et al., 2004).

### **3.3 Othering in the Nursing Literature**

The theoretical framework on Othering has been used to explore a wide range of topics in the nursing literature, including interprofessional communication, power relations, and hostile workplace in the context of nursing practice and nursing education (Jackson, Hutchinson, Everett, Mannix, Peters, 2011; Weeks, 2005), immigration and racism (Grove & Zwi, 2006; Johnson et al., 2004; Magnusdottir, 2005; Omeri & Atkins, 2002), race and identity (Canales, 2004; Canales & Bowers, 2001; Mkandawire-Valhmu, Kako & Stevens, 2010), nursing education, nursing research, and cultural competence (Campesino, 2006; Drevdahl, Canales & Dorcy, 2008; Gray & Thomas, 2005; Jackson et al., 2011; Ogle & Glass, 2006; Weeks, 2005; Westerholm, 2009), nursing practice in regards to psychiatry, forensic nursing, and HIV/AIDS (Chan, 2009, Hamilton & Manias, 2006; Holmes, 2003; Jacob, 2010; MacCallum, 2002;

Peternej-Taylor, 2004; Warner & Gabe, 2004; Wright, Haigh & McKeown, 2007), and obesity (Aranda & McGreevy, 2012; Thompson & Kumar, 2011).

### **3.3.1 Interprofessional Communication, Power, and Hostile Workplaces**

Weeks (2005) applied this framework within the context of perioperative nursing, with a particular focus on interprofessional communication and power relations between nurses and physicians. In this study, the concepts of exclusionary and inclusionary practices were applied to critically examine nurse–physician communication and to discuss power structures that are at play in interprofessional communication (Weeks, 2005). Weeks (2005) found that both nurses and physicians use inclusionary practices when they interact to promote collaboration and cohesiveness within the health care team. Additionally, the findings of the study reinforced the need for nurses to be cognizant of and to acknowledge the power structures in their workplace as a way to counteract exclusionary practices that may take place in the context of interprofessional communication (Weeks, 2005). More recently, Jackson and colleagues (2011) used the same framework to study power, workplace hostility, and interpersonal conflict in nursing, with a particular emphasis on the experience of nursing students. Their findings pointed to a lack of published research on inclusionary practices and to the need to conduct more research on coping strategies used by nursing students in hostile workplaces and on counteractions to exclusionary practices in clinical practice (Jackson et al., 2011).

### **3.3.2 Immigration and Racism**

The framework on Othering has a strong presence in the nursing research that focuses on immigration, racism and cultural competence (Grove & Zwi, 2006). Grove and Zwi (2006) used this framework to describe how forced migrants were Othered, and experienced social exclusion and marginalization as a result. Grove and Zwi (2006) found that migrants encountering exclusionary practices were much more likely to show distrust, dislike and resentment based on

past experiences and residual feelings (Drevdahl & Dorcy, 2007). Magnusdottir (2005) applied the same framework to explore the lived experiences of foreign nurses who were working at hospitals in Iceland. In this study, foreign nurses reported experiences of racism, accounts of being disliked by other staff members, and feelings of being an outsider (Magnusdottir, 2005). Based on the research findings, the researcher argued that many of the nurses who took part in the study had become used to exclusionary practices. The findings reported by Magnusdottir (2005) are consistent with findings of Omeri and Atkins (2002), who studied the lived experiences of immigrant nurses who reported experiences of racism at work in Australia. Racism was also studied by Johnson and colleagues (2004), who found that racism in nursing practice often coexists and conflicts with professional values such as equality and justice. Their analysis of interactions between nurses and South Asian immigrant women shed light on exclusionary practices that are encountered in health care settings. Interestingly, they noted that some of these settings create conditions for exclusionary practices to take place even when nurses and patients have similar racial, ethnic, and cultural backgrounds (Johnson et al., 2004).

### **3.3.3 Race and Identity**

The framework has also been applied in the context of research on race and identity. For example, Canales (2004) described how women's native identity was often used to label them as Others in health care settings. Women who took part in her study reported various experiences of being Othered during encounters with health care providers and also reported many instances of being discouraged from accessing health care services (Canales, 2004). Similar findings were also reported by Browne (2007), who conducted a study in the Canadian context and reported that discourses and assumptions about Aboriginal people, culture, and presumed differences shaped routine clinical encounters. In another study conducted by Canales and Bowers (2001), it was reported that Latina nurse educators experienced both

exclusionary and inclusionary practices in academic settings. Exclusionary practices were described as the direct outcome of being identified as “different” (or Other) and as outsiders in these particular settings (Canales & Bowers, 2001). However, it was noted by Mkandawire-Valhmu, Kako and Stevens (2010) that exclusionary practices experienced by faculty members who are “culturally different” can be diminished through mentorship, academic support and knowledge promotion. Interestingly, the study conducted by Canales and Bowers (2001) described inclusionary practices as tools that could be used by faculty to encourage the provision of competent care to all persons who are perceived as different (Canales & Bowers, 2001). It was believed that faculty members who are “culturally different” could, in fact, incorporate inclusionary practices in nursing education.

### **3.3.4 Nursing Education, Nursing Research, and Cultural Competence**

In 2008, Drevdahl, Canales and Dorcy (2008) applied the Othering framework to cultural competence in nursing, with the specific objective of studying the way “cultural difference” operates in nursing practice. Along the same line, Westerholm (2009) applied the framework to study cultural competence and cultural sensitivity in community nursing practice. The researcher stressed that nurses need to be able to take the role of the person who is culturally different to be able to imagine the feelings and experiences that a particular event may create (Westerholm, 2009). Ogle and Glass (2006) also documented this in the context of nursing research. According to Campesino (2006), role taking (as an inclusionary strategy) should be developed in the context of nursing education as a way to promote the use of inclusionary Othering in practice. It should, however, be noted that this strategy is particularly challenging to develop when nursing curricula are primarily developed from a “White dominant perspective” (Campesino, 2006, p.302). This perspective tends to focus on those who are perceived as “culturally different” (as Others) rather than to reinforce ways to connect through difference to foster cultural competence. Gray and Thomas (2005) found that nursing students often lacked

strategies to identify detrimental exclusionary practices they encountered in their practice and to understand their impact. They concluded that nursing education needs to pay more attention to cultural competence with respect to Othering practices (Gray & Thomas, 2005).

### **3.3.5 Nursing Practice: Psychiatry, Forensic, and HIV/AIDS**

The Othering framework has been used extensively in forensic psychiatric nursing. For example, Peternelj-Taylor (2004) studied the hierarchical power structures and the use of specific language in forensic psychiatric settings as two specific conditions that reinforce exclusionary practices. The researcher was mindful of the fact that nurses might not be able to use inclusionary practices in these particular settings to effectively engage with patients who are identified as dangerous and violent offenders (Peternelj-Taylor, 2004). The researcher concluded the article by promoting the use of inclusionary strategies to encourage nurses to learn about themselves and their patients, to empower nurses, and to transform nurse-patient interactions (Peternelj-Taylor, 2004). Similar findings were described by Jacob (2010), who conducted a study to look specifically at the role of fear in nurse-patient interactions, and by Holmes (2003), who conducted a study on nursing practice in forensic settings. The same framework has also been used in psychiatric nursing research (Hamilton & Manias, 2006; Johnson et al., 2004; MacCallum, 2002; Peternelj-Taylor, 2004; Warner & Gabe, 2004; Wright, Haigh & McKeown, 2007). Furthermore, it has been applied to nursing practice to look at the experiences of people living with HIV who were primarily exposed to exclusionary practices in health care settings (e.g., providers' practices of avoiding essential nursing duties and failing to provide competent nursing care). This study found that exclusionary practices were often perpetuated by providers who lacked education and training related to HIV/AIDS (Chan, 2009).

### 3.3.6 Obesity

Only two studies that specifically applied the framework to PLWO were identified in the nursing literature (Aranda & McGreevy, 2012; Thompson & Kumar, 2011).

Thompson and Kumar (2011) studied the perceptions as Others of PLWO who chose not to make lifestyle or dietary changes after public health campaigns. PLWO were perceived as having chosen not to “take responsibility for their own health,” although they were aware of the consequences and likely outcomes (Thompson & Kumar, 2011, p.113). Thompson and Kumar (2011) noted that PLWO were often categorized into two distinct groups, as persons who deserve or don’t deserve medical treatment and care. This categorization process ignored the role of context, immediate environment, financial means, culture, informational and practical needs, genetics, and so forth (Thompson & Kumar, 2011). As a result, the focus was placed solely on the individual’s behaviour or lack of response to public health campaigns (Thompson & Kumar, 2011). It was noted that this process could perpetuate intolerance, exclusion, marginalization, and persecution of PLWO who appear to be unwilling to change their eating habits and lifestyle practices (Thompson & Kumar, 2011). It was also suggested that it might contribute to greater health disparities and social inequities (Thompson & Kumar, 2011).

Aranda and McGreevy (2012) studied Othering by looking at the experiences of overweight nurses who interacted with overweight patients in clinical practice. Nurses reported being exposed to exclusionary practices because of their physical appearance and because they did not conform to “what a nurse should look like.” This experience either assisted them in empathizing with their overweight patients or made it more difficult for them to interact with this specific patient population, because they were viewed as poor role models of healthy lifestyles (Aranda & McGreevy, 2012). Because these nurses were thought of as poor health role models, they felt uneasy about providing healthy lifestyle choices (Aranda & McGreevy, 2012). In this

study that used the Othering framework of Canales, nurses' ability to connect with overweight patients was examined in great detail. It was argued that the framework could assist researchers to understand nurse–patient interactions as well as individual perceptions of self, that is, how patients and nurses viewed their larger than “normal” body size (Aranda & McGreevy, 2012). The ability to connect with the Other was described by the researchers as a process of embodied empathy-in-action that shared many similarities with the process of role taking described by the original work of Canales (Aranda & McGreevy, 2012).

Thus far, there has been very little use of Othering (Canales, 2000, 2010) with the PLWO population, and in the future, the application of Canales' framework may prove to be extremely useful for nurses who work with these persons within an ICU environment. Already successfully used with a wide variety of stigmatized populations who experience Othering, this framework may lead to new strategies for interacting safely with this specific patient population. Canales (2000, 2010) framework provides an innovative way to elucidate how ICU nurses interact with the PLWO as it focuses on both the positive and negative social aspects of these interactions, while also recognizing the importance of environmental, individual and situational influences.

## CHAPTER 4

### METHODOLOGICAL CONSIDERATIONS

This chapter outlines the methodological considerations of this study. The research design and research setting are described. The data collection and analysis processes are then delineated, followed by a detailed account of rigor criteria and ethical considerations for this study.

#### **4.1 Research Design**

This study was based on a qualitative research design that incorporates explorative and descriptive properties. These properties are extremely valuable when researchers seek to examine and describe complex phenomena such as the experiences of ICU nurses who provide care to PLWO, but they are also useful in their contribution to knowledge development in research domains where few investigations have been undertaken (Creswell, 2013). This study was specifically designed to explore the experiences of ICU nurses and to produce an in-depth description of these experiences. According to Creswell (2013), this level of description can only be achieved “by talking directly with people, going to their homes or places of work, and allowing them to tell the stories unencumbered by what we expect to find or read in the literature” (p.48). A research design that requires direct contact with participants and detailed accounts of their experiences, therefore, was best suited to answer the research questions and to produce a complex understanding of the research problem (Creswell, 2013).

In 2003, Caelli, Ray and Mill observed an increase in the number of qualitative studies that had not used an established qualitative methodology, such as phenomenology or ethnography, grounded theory, and so forth. These researchers referred to these studies as “generic qualitative studies” and coined the term “generic qualitative research” (Caelli et al., 2003, p.1). This study fits within the field of generic qualitative research because it did not use an existing qualitative methodology to guide the data collection and the analysis process. Four

basic requirements, which were brought forth by Caelli and colleagues (2003), were presented as necessary to produce a well done generic qualitative study including : 1) the researcher's theoretical position, 2) the distinction between method and methodology, 3) the explicit description of rigor criteria, and 4) the identification of the researcher's analytic lens. For this study, the theoretical framework of Canales' (2000) was described by the researcher and used to direct every step of the research process (i.e., interview guide, data analysis, presentation and discussion of findings). The methodological approach of Applied Thematic Analysis (as described by Guest, MacQueen and Namey, 2012) was used to analyze the data. Tracy's (2010) rigor criteria were applied throughout the data analysis to ensure high quality research was achieved. Finally, the researcher's analytic lens was made explicit in Chapter 1 and consistently used throughout the project. The researcher's epistemological position clearly expressed what the researcher's goals and aspirations of this study were and what was hoped to be achieved. All the factors that were discussed thus far were openly asserted by the researcher to ensure transparency for the reader. They will also be discussed in this chapter.

Given the lack of research specific to ICU nurses and their experiences of providing care to PLWO, the use of a qualitative design allowed the researcher to engage with the research data using an inductive approach while working very closely with the accounts of participants (words, expressions, metaphors, examples, interrogations, reflections, and so forth) (Creswell, 2013). The use of an inductive approach was necessary throughout the data analysis process to identify codes and patterns, to build themes and sub-themes, and to develop an explanatory scheme from the "bottom up" (Creswell, 2013). This process was used inductively to work with research data from the simplest of units to increasingly more abstract conceptualizations of the experiences described by participants (Creswell, 2013). Over the course of the analysis, the researcher worked back and forth between the emerging themes (and sub-themes) and the

original data. This process was repeated until a comprehensive set of themes and sub-themes was identified by the researcher (Creswell, 2013).

This qualitative research study included a number of important steps: 1) comprehend the phenomenon under study; 2) synthesize a portrait of the phenomenon that accounts for complexities, tensions, patterns, commonalities, and incongruences; 3) theorize about how and why these relations appear as they do in the research data; and 4) re-contextualize or put the research findings back into (a) the research context in which participants located their experiences, (b) the existing literature and how others have articulated (theoretically and methodologically) the research problem thus far, and (c) the theoretical understandings of Othering in health care (Morse, 1994). These steps guided the researcher at every stage of the research process, and provided the necessary framework to ensure that research findings feature rich and diverse descriptions of participants' experiences, in-depth discussions of methodological and theoretical implications, and new insights into a research phenomenon that has been largely overlooked in nursing.

#### **4.2 Research Setting**

This study was conducted on two intensive care units at two sites of a 1,155 bed, multi-site, tertiary care health centre located in a large urban centre in eastern Ontario. Registered nurses (RNs) who work at this health centre were asked to implement the organization model of care in practice. This model was intended to guide nurses in the ways that they provide patient care throughout the centre (including inpatient and outpatient settings) and to ensure consistency in nursing care (Confidential Document, 2009). This model includes direct care principles specifically focused on the patient, the family and the nurse, as well as clinical day-to-day principles that support nursing practice and value of the clinical expertise (Confidential Document, 2009). It also reinforces the need for ongoing communication and nurse-led patient

education (Confidential Document, 2009). Furthermore, it states the importance of limiting the number of nurses assigned to the same patient as a way to promote continuity of care within the health centre (Confidential Document, 2009).

#### **4.2.1 Research Sites**

This study was conducted on two intensive care units (hereafter referred to as ICU #1 and ICU #2) at two separate sites. The two units are designed to provide care to acutely ill, medically unstable patients who suffer from a wide range of illnesses and conditions. These can include infections leading to sepsis or septic shock, cancer and cancer treatment-related complications, cardiopulmonary arrests, cardiogenic shock, respiratory failure, cardiac and/or respiratory support for post-surgical patients, distributive shock, myocardial infarctions, and heart failure. These two units offer specialized medical care such as thoracic or vascular surgery, trauma surgery, neurosurgery, general surgery, and specialized medical expertise in a number of subspecialties (e.g., internal medicine, nephrology, oncology, and so forth). Together, the intensive care units have a total of 65 dedicated critical care beds for acutely ill patients who require complex, highly specialized, ongoing nursing care. In 2010, a total of 2300 ICU patients were admitted on these two units (Confidential Document, 2012). Patients who are admitted to the intensive care units require one-to-one nursing care, complex and highly technical interventions (including, but not limited to, medical, nursing, pharmacological interventions), and ongoing monitoring. The vast majority of patients who are admitted on these units require airway support and management. In other words, they require endotracheal intubation and ongoing ventilation. They also require ongoing interventions to ensure that they remain hemodynamically stable (e.g., vasopressors, fluid resuscitation, assistive devices for blood pressure stabilization).

The multidisciplinary teams on both units are comprised of RNs, registered respiratory therapists, occupational and physical therapists, pharmacists, dieticians, social workers, spiritual care providers and speech language pathologists (Confidential Document, 2010). A total of 323 RNs are employed between the two intensive care units. The ages of RNs who worked in the research setting at the time of the study are described in Table 1. The educational background of RNs who were employed on the two units at the time of the study ranged from a nursing diploma, to a nursing undergraduate degree, to a nursing graduate degree. All RNs were registered with the College of Nurses of Ontario (CNO) and had completed intensive care nursing training as a requirement for being able to work on the units. All RNs were able to communicate in English, and many were able to speak fluently in French.

**Table 1.** Ages of RNs working in the research setting

	<31	31-40	41-50	51-60	61-65	>65	Total
ICU #1	29	44	60	25	3	0	161
ICU #2	39	47	38	33	5	0	162
Totals	68	91	98	58	8	0	323

The health care centre employs a total of 3702 RNs, of which 3431 are female nurses and 271 are male nurses (Confidential Document, 2013). At the time of the study, 62% of the RNs employed at the health care centre were employed in full-time job positions, 31% were employed in part-time positions, and 7% were employed in casual positions (Confidential Document, 2013). On ICU #1, 68% of RNs were employed in full-time positions, 29% were employed in part-time positions, and the percentage of nurses who were employed in casual positions was 3% (Confidential Document, 2013). On this particular unit, 15% of RNs were male nurses and 85% were female nurses (Confidential Document, 2013). On ICU #2, 13% of RNs were male nurses and 87% were female nurses (Confidential Document, 2013). The percentage

of nurses working in full-time positions on this unit was 79%, while the percentage of nurses filling part-time positions was 19% and 2% for casual positions (Confidential Document, 2013). Here, it is important to clarify that this information was made available by the health care centre, and was not specifically requested by the researcher as part of the data collection process.

#### **4.2.2 Values and Standards**

The intensive care units expect all members of the health care team to practice according to certain values and standards. These values are as follows: 1) taking pride in giving care that is skilled, personal and compassionate; 2) providing care for persons from eighteen years old to elderly; 3) providing total care to all patients that encompasses physical, spiritual, emotional and socio-cultural needs; 4) striving to create a friendly and supportive environment that promotes an optimistic, yet realistic outlook; and 4) valuing the trust that has been placed in the ICU team by patients and their families (Confidential Document, 2012). All nurses working in the ICU are also expected to practice according to the following standards: 1) patients and families will be greeted warmly and will be informed of each health care professional's name and role; 2) as health professionals, they will listen with care and communicate clearly; 3) they will ensure that the patient and their family are cared for in the language of their choice; 4) the ICU team will be polite and respectful regarding all patients' cultural values, personal beliefs and abilities; 5) the patient and family will be treated as the most important member of the patient-care team and will be included in any and all patient care decisions; 6) the ICU team will go out of their way to meet the needs of the patient and family. In addition, the patient and family will be kept informed as the health team will explain what is being done, and the team will communicate what can be expected; 7) the highest level of professional standards, skills and competence will be maintained; 8) the team will practice safe care at all times, from cleaning their hands to ensuring the safety of the environment, technologies and processes. Patient safety is a top priority; 9) patient and family privacy will be protected and the patient's personal dignity will be maintained;

and 10) the ICU team will acknowledge and apologize when a problem arises. The team will actively listen and correct the problem (Confidential Document, 2012).

#### **4.2.3 Nursing Care**

The nurse–patient ratio in the intensive care units is most often one-to-one for all patients who are intubated and ventilated and for patients who require cardiac monitoring (with or without direct pharmacological interventions). The nurse–patient ratio can increase to two when patients are able to breathe on their own without additional support, present stable vital signs and overall condition, and when patients are waiting for a transfer to a “regular” medical unit. The nurse–patient ratio allows for very close monitoring and continuity of nursing care in a context where patients are at risk of exacerbating, decompensating, and requiring prompt interventions (Confidential Document, 2012). RNs who work on these units are expected to monitor their assigned patient(s) very closely and to respond to changes in airway patency, respiration, oxygen saturation, blood pressure, level of consciousness, neurological status, lab values, and clinical parameters (Confidential Document, 2012). They are required to practice autonomously while providing safe and competent care to patients with complex needs in a wide range of situations — including situations where patients require advanced cardiac life support (Confidential Document, 2012). As such, RNs are expected to work closely with other members of the health care team, initiate the right interventions to ensure patient safety, practice autonomously to achieve clinical outcomes, and act as patient advocates (Confidential Document, 2012).

RNs work a combination of twelve-hour day shifts from 07:15 to 19:15 and twelve-hour night shifts from 19:15 to 07:15. They can work up to four, twelve-hour shifts in a row, days or nights, or a combination of the two. RNs will frequently be assigned to the same patient for the day shifts and to a different patient for their night shifts. However, patients with a BMI of 30 or greater are usually not assigned to the same nurse for more than two shifts. In fact, it is not

uncommon for nurses to request a change of assignment for the following shifts if they are assigned to patients who are physically more demanding for two consecutive shifts.

Nursing practice in the intensive care units is structured around the clock and around specific routines (Confidential Document, 2012). Every morning, the members of the multidisciplinary team gather with the attending intensive care physician to complete “rounds” on each patient on the unit. At this point, the physician carefully examines each patient, and the plan of care is discussed in detail at the bedside (Confidential Document, 2012). Blood tests, x-rays, treatments and electrocardiograms are done as necessary throughout the day (Confidential Document, 2012). At the beginning of each shift, the ICU nurse receives a verbal end-of-shift report from the previous nurse (Confidential Document, 2012). The verbal report should include an in-depth description of the following: 1) the patient’s mental and physical condition, 2) the patient’s plan of care and needs in light of his condition, 3) the outcomes of procedures, tests, treatments, and interventions, and 4) the issues or challenges faced by the nurse during the previous shift (Confidential Document, 2012). Following end-of-shift report, the nurse is required to go into the room to introduce herself/himself to the patient, check any and all intravenous infusions to ensure accurate settings, confirm line placement, verify alarm settings on the monitors, and proceed with a thorough assessment of the patient (Confidential Document, 2012). Almost every patient who is admitted to the ICU receives a daily chest x-ray at 08:00, which requires immediate repositioning of the patient. Every patient admitted to the ICU is expected to be turned and positioned every two to three hours during day and night shifts. It is worth noting that this is a requirement for all patients admitted in the ICU, independently of their weight, size, autonomy, and resources. PLWO are more likely to be turned every three to four hours based on staff availability, resources (see section 4.2.4), and medical condition. It should be noted that all patients require head-to-toe assessments every four hours in addition to hourly vital signs, with extremely close monitoring on an ongoing basis.

#### 4.2.4 Physical Environment and Resources

The intensive care units are locked units and are generally closed to the public. To access one of these units, family members or relatives must contact the primary nurse before each visit in order to ensure that timing of the visit does not interfere with the plan of care or put the patient at risk if he/she is unstable. Each patient is admitted in an individual room that is large enough to accommodate additional personnel, multiple intravenous pumps, monitors, medicament carts, and equipment necessary for central line insertion, airway management and intubation, resuscitation, and so forth. Each room is equipped with monitors that record heart rate, cardiac output and cardiac pressure, venous and arterial pressures, oxygen saturation, and blood pressure. Each room is also equipped with electrical and water outlets that can accommodate highly specialized equipment for critically ill patients (e.g., hemodialysis). Each ICU has two patient attendants, one per every sixteen rooms, to assist nurses in mobilizing patients, to help with portable chest x-rays, as well as to assist with patient repositioning and personal care. Additional patient attendants are not available or specifically assigned to nurses who provide care to PLWO.

A number of rooms in both intensive care units have ceiling lifts to assist nurses with the repositioning of PLWO. There are a number of 600-lb.-capacity ceiling lifts, as well as one, 1000-lb.-capacity ceiling lift on ICU #1. ICU #2 has two, 1000-lb.-clearance ceiling lifts. In total, there are two, 1000-lb.-capacity floor lifts available, one lift per unit. There is one bariatric bed available in ICU #1 and ICU#2, and three other bariatric beds are available throughout the health centre. If multiple PLWO are admitted to ICU #1 with a body weight greater than 300 lb., additional bariatric beds must be requested by the care facilitators. Slings available for repositioning and the lifts come in 300-lb.-, 600-lb.- and 1000-lb.-capacities. If a nurse experiences difficulties with a lift or sling, or with finding staff to assist with physical tasks, this needs to be brought to the attention of the care facilitator. The care facilitator is responsible for

securing additional support or resources for the following shift. If a PLWO is admitted to a room that lacks a lift, assistance of four to five people may be required for physical tasks such as turning and positioning.

Two bariatric foot stools that hold up to 1000 lb. are available at each campus for mobilization of PLWO and to assist nurses in reaching over the sides of bariatric beds during interventions such as intubation, suctioning, central line insertion and placement confirmation, dressing changes, neurological assessment (e.g., pupils), medication administration, and so forth. It should be noted that nurses who are shorter in stature might have more difficulty reaching and stretching over the side of the bariatric beds to provide nursing care. To assist physiotherapists in mobilizing PLWO, two bariatric walkers (one has a weight clearance of 440 lb. and the other up to 1000 lb.) are available. Two additional walkers with a weight clearance of 750 lb. are available on ICU #2. Furthermore, five wheelchairs with weight capacities of 1000 lb. are available on ICU #2 and three are available on ICU #1. Two bariatric commodes are available at each unit for patients up to 750 lb. Here it is important to point out that toilets located in the rooms on both units are only able to safely support a maximum weight of 300 lb. There is one bariatric bedside chair available with a clearance of 800 lb. at both ICU #1 and #2.

### **4.3 Recruitment**

Recruitment of research participants started immediately after the approval by the Research Ethics Boards (REB) at both the health centre and the University of Ottawa (see Appendix A). The ICU educators on ICU #1 and ICU #2 were made aware of the study by email, and they expressed their support for the study. They were asked to place the posters (in French and English) in the nursing social areas and share them electronically with their nursing staff (see Appendix B). At no time was the researcher actively recruiting on these units. Potential participants were encouraged to contact the researcher by telephone or by email to signal their interest in taking part in the study. Throughout the recruitment process, the researcher remained

available to answer questions via phone or email and to clarify the objectives of the study with potential participants.

In order to be included in the study, participants had to be able to communicate in English. As previously mentioned, being able to communicate in English is a condition of employment for nurses working at the health centre where the research was conducted. While the interview was conducted in English by the researcher, documentation (recruitment posters, consent forms, and socio-demographic questionnaires) was available in both French and English. Other inclusion criteria included being 18 years and older, currently working as a nurse in ICU #1 or ICU #2, and having at least one previous experience of providing care to a PLWO in the ICU. Inclusion of participants was not based on representativeness of ICU nurses. Therefore, all participants who wished to take part in the study were included. There were no specific exclusion criteria for this study.

A purposive sample of 11 ICU nurses took part in this study. Recruitment of participants continued until data saturation was reached. Data saturation is said to occur when the researcher is no longer encountering new information during the interviews or seeing new information in the data. Research has indicated that saturation can usually be achieved after six interviews, and confirmed after twelve interviews (Guest, Bunce & Johnson, 2006). In this study, data saturation was achieved after nine interviews. Additional interviews were conducted with two participants to confirm that the point of saturation had been reached. In other words, these interviews were conducted to explore whether new data would emerge or if the data would simply reaffirm the accounts of previous participants. In the end, the additional interviews provided rich data, but did not reveal new information on the research problem.

#### 4.4 Sample

Over a period of three weeks, a total of 11 nurses were interviewed, and they each met with the researcher for a period of 30 to 60 minutes.

**Table 2.** Characteristics of research participants

Sex	Males	2
	Females	9
Age	25-29	6
	30-34	3
	35-39	1
	40-44	1
Years as RN	< 5yrs	3
	5-10yrs	6
	10-14yrs	0
	15-19yrs	1
	> 20yrs	1
Years in ICU	< 2yrs	1
	2-4yrs	3
	> 5 years	7
Education	Diploma	2
	BScN	7
	MScN	2

The age of research participants ranged from 25 years old to 44 years old. Two out of eleven participants had a college diploma in nursing, seven nurses had completed an undergraduate degree in nursing and two participants had completed a graduate degree (MScN) in nursing. Three of the eleven participants had fewer than five years of nursing experience, six participants had between five and nine years of nursing experience, one participant had between 15 and 19 years of experience, and one participant had greater than 20 years of nursing experience. One out of eleven research participants had fewer than two years ICU experience, three of eleven participants had between two and four years of ICU experience, and the remaining seven participants had greater than five years of ICU experience.

## 4.5 Data Collection

Interviewing is the most common technique used for data collection in qualitative research and it typically provides the researcher with a chance to explore the personal experiences of participants, as expressed in their own words (Creswell, 2013). For the purpose of this study, interviews were conducted on an individual basis to gain a rich description of the experiences reported by ICU nurses who provide care to PLWO, and to explore their personal views, concerns, interrogations, and insights. Interviews were found to facilitate an interactive dialogue between the participant and the researcher (Halcomb & Davidson, 2006). This was particularly important, considering the epistemological position of the researcher and the theoretical underpinnings of this study. In addition to completing a one-on-one interview with the researcher, each research participant was asked to answer a few questions prior to the interview to document age, sex, nursing education background, years of experience as a registered nurse, and years of experience as an ICU nurse (see Appendix C). The data collected was used to describe the sample, and is summarized in Table 2.

Each participant was asked to take part in a 30 to 60 minute, face-to-face, semi-structured, in-depth interview with the researcher. The date and time of the interviews were arranged based on the availability of the participants, and these were confirmed when participants contacted the researcher to signal their interest in taking part in the study. The researcher did not have access to the personal information (email, phone number, personal work schedule, etc.) of participants. The ICU nurse managers or educators had no knowledge of who took part in the study, and the confidentiality of participants was maintained at all times. The interviews were not conducted during work time and did not take place on the units. Interview locations were determined based on the preferences and availabilities of participants. If a participant did not wish to be interviewed at the health centre or at a preferred location, the

interview was conducted in a closed office at the University of Ottawa. Throughout data collection, the researcher remained flexible and open to preferences of research participants regarding interview location.

For the purpose of this study, each interview was audio-recorded using a digital voice recorder, saved as an audio file on a password protected computer, transcribed, and reviewed by the researcher promptly after each interview. All audio files were transcribed verbatim to provide valid descriptions of the information shared during the interview process and to set the stage for the analysis. During the interview process, participants were asked to describe their experiences as ICU nurses working with PLWO, with a particular focus on daily routines, nursing interventions, clinical considerations, and challenges faced in practice (see Appendix D). They were also asked to share personal experiences of providing care to PLWO in the ICU context and to reflect on both positive and negative experiences. Participants were encouraged to expand on the practices or strategies developed to care for PLWO, to describe their needs with respect to this patient population, and to identify areas of improvement in the ICU context. After each interview, detailed field notes were documented in a research journal to critically reflect on the interview process and overall impressions (Halcomb & Davidson, 2006).

Field notes were kept throughout the data collection process to capture ideas, questions, emotions, body language, observations and situational elements that required consideration during the analysis process (Polit & Beck, 2012). These notes enriched the data collection process by providing a description of context and insights into the experience of conducting interviews with participants (Polit & Beck, 2012). They were both descriptive and reflective of the process, which allowed for a more rigorous approach to each additional interview (Polit & Beck, 2012). Field notes were kept during the analysis to maintain a narrative account of what happened at every step of the process and to explicitly document questions, decisions, and actions. These notes assisted the researcher during the analysis and the description of findings

(see Chapter 5). All research journals were kept in a locked cabinet at the University of Ottawa in order to make sure that field notes were secured throughout the duration of the study.

#### **4.6 Data Analysis**

For the purpose of this study, data collection and analysis followed the methodological framework of Applied Thematic Analysis (ATA), as adapted and described by Guest, MacQueen and Namey (2012). This framework was developed to assist qualitative researchers in collecting and analyzing data in a systematic and rigorous way. It relies on an inductive approach and draws on established techniques to generate themes (Guest et al., 2012). In summary, ATA involves four general steps: 1) read transcriptions, 2) identify possible themes, 3) compare and contrast themes, identifying structure among them, and 4) produce a thematic scheme to describe the research phenomenon (Guest et al., 2012). Every transcription was read carefully and the content of the transcription was verified by the researcher twice, using the audio file. Expressions, acronyms, hesitations, silences, and questions were clearly identified in the transcription to ensure that content was representative of the interview process. Data analysis began with the initial coding of the interview identified as the “key interview.” This interview was selected because it offered rich insights, various examples, and balanced descriptions of both positive and negative experiences. The objective of initial coding is to reveal, name, summarize and label, line by line, the contents of the transcription (Guest et al., 2012). This initial coding process was completed for two additional interviews.

As the process continued and commonalities began to emerge, the researcher was able to regroup specific codes into broader codes, and, eventually, to regroup them into themes as they developed. These themes were then used to analyze and colour-code subsequent interviews. Throughout this process, the researcher worked carefully to ensure that themes were compared and contrasted, that interrelationships were mapped, and that connections and

patterns were identified (Guest et al., 2012). The researcher aimed to produce a scheme that took into consideration these interconnections and patterns that characterized the research phenomenon (Guest et al., 2012). All relevant sub-themes that emerged during the analysis were labelled and regrouped under a common theme. These sub-themes were meant to describe and clearly identify distinct dimensions in the research data (Guest et al., 2012). Once the themes and sub-themes were fully developed, the transcriptions were reassessed to make sure that they corresponded and reflected the research data (Guest et al., 2012). During this process, direct quotes were identified to support each sub-theme, and specific quotes were selected to develop the outline for the presentation of the research findings. The final stage of the data analysis allowed the researcher to produce a thematic scheme to describe the research phenomenon. This thematic scheme is presented in Chapter 5.

For the purpose of this study, Canales' framework (as described in Chapter 3) was used to guide the analysis of the research data. As such, this framework provided the theoretical underpinnings for data analysis, and offered distinct terminology from which to draw when identifying themes. The framework and its conceptual rationale acted as the theoretical underpinnings of the research study (Polit & Beck, 2012). As in most qualitative studies, this framework was part of the research tradition that guided the study's methodology (Polit & Beck, 2012). Consequently, this framework was the theoretical lens and the following quote explains its' impact on the research process:

"The theoretical lens from which the researcher approached the phenomenon, the strategies that the researcher uses to collect or construct the data, and the understandings that the researcher has about what might count as relevant or important data in answering the research questions are all analytic processes that influence the data" (Thorne, 2000, p.68).

The framework that was chosen by the researcher provides insight into the researcher's world view and views of nursing, which shape how the concepts were developed and refined during

the analytical process (Polit & Beck, 2012). The theoretical framework is discussed in more detail in Chapter 3.

#### 4.7 Rigor

The researcher used eight criteria to ensure the rigor of the study (Tracy, 2010). These criteria are summarized in Table 3. Tracy (2010) intended for the criteria to be flexible in their use and dependent upon the aims of the study. The following paragraphs will describe some of the steps that were taken by the researcher to ensure that this study was conducted in a rigorous manner.

**Table 3.** Rigor criteria (adapted from Tracy, 2010, p.840).

Worthy topic	The topic of the research is: <ul style="list-style-type: none"> <li>• Relevant</li> <li>• Timely</li> <li>• Significant</li> <li>• Interesting</li> </ul>
Rich rigor	The study uses sufficient, abundant, appropriate and complex: <ul style="list-style-type: none"> <li>• Theoretical constructs</li> <li>• Data and time in the field</li> <li>• Data collection and analysis processes</li> <li>• Samples</li> <li>• Contexts</li> </ul>
Sincerity	The study is characterized by: <ul style="list-style-type: none"> <li>• Self-reflexivity about subjective values, biases, and inclinations of the researcher</li> <li>• Transparency about the method and challenges</li> </ul>
Credibility	The research is marked by: <ul style="list-style-type: none"> <li>• Thick description, concrete detail, explication of non-textual knowledge, and showing rather than telling</li> </ul>
Resonance	The research influences, affects or moves particular readers or a variety of audiences through: <ul style="list-style-type: none"> <li>• Aesthetic, evocative representation</li> <li>• Transferable findings</li> </ul>
Significant contribution	The research provides a significant contribution: <ul style="list-style-type: none"> <li>• Conceptually/theoretically</li> <li>• Practically</li> <li>• Morally</li> <li>• Methodologically</li> <li>• Heuristically</li> </ul>
Ethical	The research considers: <ul style="list-style-type: none"> <li>• Procedural ethics (such as human subjects)</li> </ul>

	<ul style="list-style-type: none"> <li>• Situational and culturally specific ethics</li> <li>• Relational ethics</li> <li>• Exiting ethics (leaving the scene and sharing the research)</li> </ul>
Meaningful coherence	<p>The study:</p> <ul style="list-style-type: none"> <li>• Achieves what it purports to be about</li> <li>• Uses methods and procedures that fit its stated goals</li> <li>• Meaningfully interconnects literature, research questions, findings and interpretations with each other</li> </ul>

Tracy (2010) defines a *worthy topic* as “interesting and point[ing] out surprises and issues that shake readers from their common sense assumptions and practices” (p. 841). She goes on to state that “this is why studies of little known phenomena or evocative contexts are intrinsically interesting” (p.841). This study explored a worthy topic by focusing on a domain where few investigations have been undertaken and by exploring a research problem that is relevant to ICU nursing and nursing more generally, timely, given the current context and patient population admitted to the ICU, significant, and interesting.

According to Tracy (2010), *rich rigor* is “judged by the care and practice of data collection and analysis procedures” (p. 842). In this study, rich rigor was demonstrated by using an appropriate theoretical framework, developing an in-depth understanding of the context, spending sufficient time in the field, and providing a comprehensive description of the research findings. Furthermore, it was important to demonstrate rigor at various stages of the analysis process: starting with the organization of raw data, followed by the transformation of raw data into codes and themes, and by the development of a thematic scheme.

This study established *sincerity* through self-reflexivity and transparency (Tracy, 2010). Sincerity was evidenced by self-reflexivity about personal experiences, professional experiences, and epistemological stance as a researcher (for example, see Preface and Chapter 1). The researcher exhibited self-reflexivity by being introspective, reflecting on personal biases and motivations, and discussing professional insights with respect to the ICU

context and the experience of nurses who provide care to PLWO. The researcher kept field notes throughout the research process. These notes played an important role in promoting self-reflexivity and were shared with the thesis supervisor at various steps of the data collection and analysis.

The researcher remained honest and transparent about the methods, successes, issues, and limitations of the study. As suggested by Tracy (2010), the study's challenges, twists and turns, as well as the ways the research focus altered and transformed over time, were made clear in the field journal. Transparency was also upheld through keeping an audit trail to provide a clear path of the researcher decisions and activities (Tracy, 2010). These were noted in the field journal, and relevant documents (electronic and paper copies) were archived when needed to maintain an audit trail. Finally, the researcher displayed transparency in the thesis by highlighting participant contributions, identifying funding sources, and acknowledging the support of key actors in the research process, of colleagues, and of the thesis committee.

The *credibility* of this study was demonstrated through the use of a thick description of research findings and through the use of "multivocality" (Tracy, 2010). Multivocality refers to a researcher's intense participation with study participants, which allows for more nuanced analysis with deeper meanings observed in the interview data (Tracy, 2010). The researcher attempted to engage participants during the interview (e.g., adopting a conversational interviewing style at times, or using familiar terminology to ask questions) and to view the participant's responses from different perspectives (including the insider perspective of an ICU nurse). This approach was particularly useful during data analysis process.

The *resonance* of this study was exhibited through the aesthetic merit of the thesis as well as the transferability of the research findings (Tracy, 2010). Aesthetic merit was demonstrated through the clarity of findings and by providing descriptions that can be easily

understood by the target audience. This particular rigor criterion was reinforced through the use of direct quotes to support themes and sub-themes. Transferability of the research findings across contexts, settings, populations, circumstances and situations was discussed in the thesis (see Chapter 6) to ensure resonance. Furthermore, the researcher acknowledged the limits of transferability by discussing how the research findings are specific to the ICU context and to the provision of nursing care to highly complex and acutely ill PLWO.

This study provided a *significant contribution* to nursing research by addressing gaps in current knowledge, practices and research on the topic (Tracy, 2010). The researcher was vigilant and mindful of ethical considerations throughout the research process; this will be discussed in the next section.

Lastly, *meaningful coherence* was attained by meeting the objectives of the study and answering the predetermined research question (Tracy, 2010). The methods and practices used were well paired with the theoretical framework and chosen research paradigm because of foundational similarities between the critical social theory epistemological position and the Othring framework (which were discussed in Chapters 1 and 2) (Tracy, 2010). Finally, the literature was effectively integrated with the research foci, methods and findings (Tracy, 2010).

#### **4.8 Ethical Considerations**

The researcher ensured that ethical considerations included procedural ethics, relational ethics, and exiting ethics (as described by Tracy, 2010). The following paragraphs will describe some of the steps that were taken by the researcher to ensure that this study was conducted in an ethical manner.

Before submitting the project to the Research Ethics Board (REB), a presentation was made to the ICU research committee to gain clearance for the study. In addition, the medical

director and the nurse managers of the two units were asked to provide written consent for the study to be conducted in the designated settings (ICU #1 and ICU #2) (see Appendix E). The research proposal and additional documents (e.g., recruitment posters, consent forms, pre-interview questionnaires) were approved by the REB at the research site and the REB at the University of Ottawa. The study was conducted by the researcher under the direct supervision of her thesis supervisor and the members of her thesis committee.

All participants approached the researcher for participation in the study without coercion or on-site recruitment. Each participant was asked to read and sign the information/consent form before the interview (see Appendix F). The information/consent forms described the purpose of the study and what it entailed. The form explained how confidentiality was going to be maintained throughout the study, and detailed the rights of study participants. The researcher reviewed each section of the form and answered questions of participants when needed. The participants were made aware (by the researcher and in the consent form) that they could discontinue participation in the study or withdraw from the study at any time in the study process without any negative consequences. The participants were also made aware and consented to the use of direct quotes in the thesis and in any publications. The researcher ensured that each participant had a copy of the signed consent form with the researcher's contact information, in case any questions arose during the interviews or after the interviews were conducted. Contact information of the thesis supervisor and the REBs was also made available to participants.

Confidentiality of the study participants was maintained in a number of ways. All contact information that was obtained to arrange for the interviews to take place was destroyed by the researcher (i.e., phone number or email). Immediately before the interview, a unique alphanumeric code was randomly assigned to each participant. This code replaced the name

of the participant on the audio file and on the transcription. The names of participants and their assigned codes were kept on a master list, which was kept in a locked file cabinet, separate from the interview data, in the thesis supervisor's office at the University of Ottawa. All identifying information (places, names, etc.) was automatically removed from the transcription by the researcher. The consent forms were available to the researcher and her thesis advisor only. These forms were kept in a locked unit in the thesis supervisor's office at the University of Ottawa. Throughout the course of the study, all files (except the master list) were stored in a locked cabinet in a locked office in a research space of the thesis supervisor. This research space was password protected at all times, and could only be accessed by a small number of people.

During the study period, the researcher kept a copy of the audio files and transcriptions on a password protected and encrypted laptop computer located in the research space (same as above), which could be accessed by the researcher only. An encrypted laptop was used to ensure the safekeeping of the data. As per the research ethics board (REB) at the research site, the audio files were deleted immediately upon the completion of transcription by the researcher. All electronic documents were secured with passwords known only to the researcher and her supervisor. As per REB requirements, the research documents will be kept for ten years (2013-2023) in a locked unit of the thesis supervisor's office. The documents will be destroyed after this period through shredding and deletion of electronic documents.

For this research study, there were no risks beyond what a person would normally encounter in daily life. The researcher provided participants with flexible availabilities to minimize the impact on their personal time and schedule. The researcher took the necessary steps to ensure that confidentiality of research participants would be maintained at all times throughout the study and after (including the publication and presentation of research findings). The researcher ensured that findings were presented in a manner that avoided unjust or

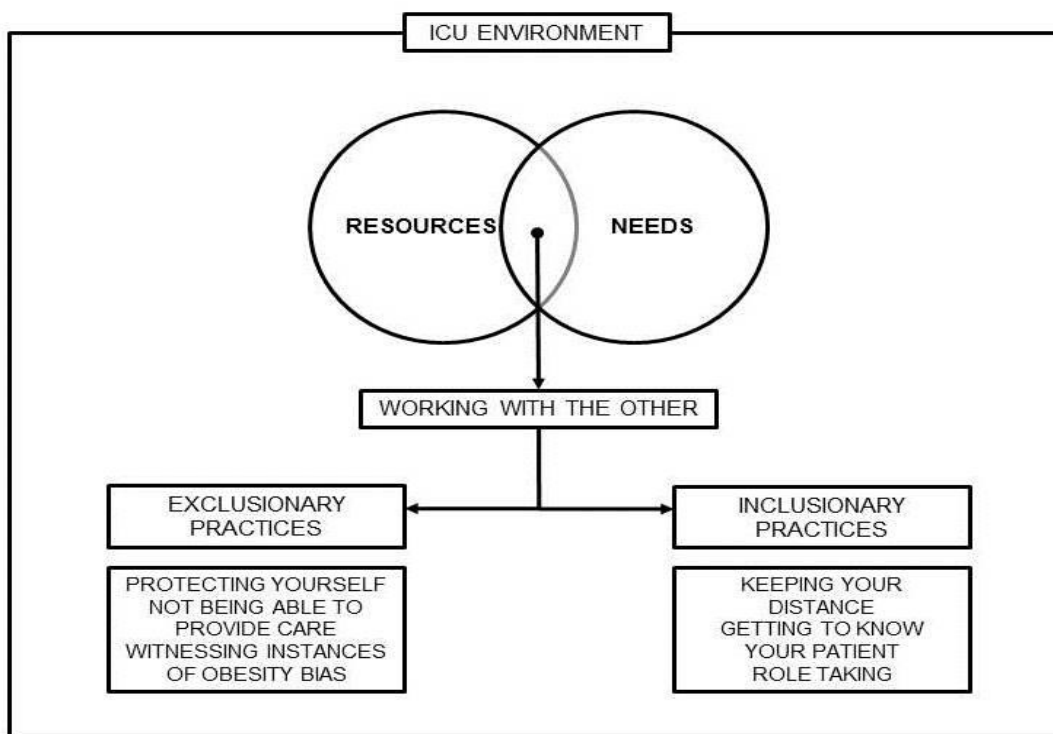
unintended consequences for the participants. The possible benefits associated with the participation in this research project included participants contributing to the development of knowledge in the field of intensive care nursing and the improvement of clinical care provided to PLWO in intensive care settings. This study was an opportunity for ICU nurses to share their experiences working with PLWO and to identify their needs as clinicians (support, training, guidelines, etc.). By taking part in the study, participants were able to contribute to more research being conducted on this topic and to work towards the enhancement of the overall care and nursing services offered to PLWO in intensive care settings.

## CHAPTER 5

### RESEARCH FINDINGS

This chapter will present the research findings based on three themes. The first theme will describe how the PLWO become Other in the ICU context. The second theme will focus on exclusionary Othering and how it manifests itself in the way PLWO are differentiated, cared for, and viewed in the ICU context. The third theme will shed light on inclusionary Othering in the form of strategies that are used by ICU nurses to engage with PLWO in a way that is inclusive and transformative. Finally, the last theme will concentrate on the ICU environment itself and the resources available (or not available) to nurses, with a particular emphasis on the needs of nurses who provide care to PLWO. The terms “participants” and “nurses” are used interchangeably throughout this chapter to facilitate the presentation of the findings.

**Figure 2.** Overview of research findings



## 5.1 Working with the Other

The analysis revealed that nurses who work in the ICU construct PLWO as being “different”; that is, nurses consider that PLWO are “different” from other “normal size” patients in the ICU and require “different” nursing care. During the interviews, nurses described working with PLWO as causing “extra physical strain” (Nurse 1), as being “physically more demanding” (Nurse 1), “work intensive” (Nurse 2) and “tiresome” (Nurse 3), as requiring “a lot more physical effort” (Nurse 4), and as being overall just “harder” (Nurse 4) than working with other patients in the ICU. They also considered that providing care to PLWO in the ICU was “a bigger ordeal” (Nurse 5). This negative differentiation occurred in the interviews when PLWO were seen as physically more demanding and requiring more work. It became evident that excess body weight and the demands this placed on ICU nurses played a crucial role in the construction of PLWO as a separate category of patients.

All of the nurses interviewed described the experience of working with PLWO by providing concrete examples of the physical strain, challenges, limitations, difficulties, complexities, delays, and complications that come into play when providing ICU nursing care. The subsequent quote illustrates this point:

When there are other people around, especially if you don't have an appropriate lift in the room, right. So, your... your logistics take more time to, to set up.... and then, to do, everything else just takes longer and it takes more physical effort. So checking the lines and tubes, you have to reach further over the patient, which, first off, doesn't make a big difference, but over the course of the 12 hours shift, always leaning over a patient to check for their lines, to listen to their lung sounds, to listen to their heart sounds, to listen to their belly, it's more tiresome than on a regular patient when you can just put your arm out. (Nurse 3: lines 218-224)

The physical difficulties noted by participants included (a) requiring more people to help assess, turn, bathe, transfer, reposition, and mobilize PLWO; (b) having to work with larger-size dressings and ask other team members to help with dressing changes (i.e., lifting skin folds); (c) needing additional help (up to three persons) to complete simple tasks, such as moving a limb, despite

having access to a mechanical lift and other bariatric equipment; and (d) requiring more time to organize nursing care and gather the staff needed to complete physical tasks.<sup>1</sup>

During the analysis, it was noted that these difficulties varied in intensity based on the physical size of the nurse. This is not to suggest that male nurses and female nurses who are physically taller, stronger, and bigger do not experience the same difficulties. It only serves to illustrate the importance of taking into account the physical capacity of nurses as well as how that impacts the way they experience the difficulties listed above and, most importantly, how they feel about providing care to PLWO, as suggested by the following quote:

But I know that, especially hygiene care in obese patients is a little bit harder to do, especially for me. I'm quite small...and it does require a lot of physical strength to, let's say, bathe a patient who is, is obese and to... especially patients who are unconscious, especially the ones who are unstable and unconscious on a ventilator and who are sedated. You have to do all the moving, even if it's, a normal size patient, it still requires a lot of work... so having patients that are obese kind of increases the strength and workload as in sometimes it takes more resources to move these people and to be able to give them the basic hygiene care that they deserve. So I guess what I've learned from these patients is that sometimes it just requires, it requires more resources, it requires more organization. (Nurse 4: lines 60-70)

Overall, nurses who were interviewed considered that working with PLWO required more time, more work, more physical effort, and more nursing care in general. Nurses found that more nursing care was required because of the medical acuity and the complexity of the patients. For instance, the next participant highlights that ICU nurses have to take charge of *and* plan for numerous comorbidities in addition to acute health conditions:

Well most of them are, are diabetic. So a lot of them are on the sliding scales insulin which then require, you know, Q1 to Q3 glucoscans and.... they often have dressings and peripheral vascular disease, you know, I mean, those types of dressings where they come in with, ulcers or that kind of stuff. Some of them have... a lot more comorbidities too. And they're just like breathing wise...It's harder to ventilate them. (Nurse 2: lines 190-199)

---

<sup>1</sup> The resources available to assist nurses in caring for PLWO will be discussed in more depth in section 5.3.

On numerous occasions, nurses stated they could not provide care to PLWO the same way they provide care for other patients in the ICU because of the physical effort and resources needed for routine care (i.e., hygiene care, turning and positioning, and so on).

I just think it's more physically demanding, to the people taking care of that person... it requires more staff sometimes, like if you need to turn that person or, you know, lift them in whatever way like you need more people to come help you. Sometimes staff is not available. Sometimes you end up doing it not as frequently as maybe you should because of that. And just because like it hurts, right, it hurts your back and you end up really tired. (Nurse 6: lines 11-16)

They also felt somewhat limited when performing nursing skills (i.e., auscultating, monitoring, palpating, medicating and so on) and could not practice the “same way” or with the same amount of time and effort. The next quote describes how this impacts the quality of the care provided in the ICU context.

I just think, the nursing care is different because more people are needed, I guess, to provide care to one patient, like bathing is a bigger ordeal — for lack of a better word — than it would be for, someone who's not obese. But in terms of like how their care is different.... I don't really know if they receive different care. I just don't know if their care, their personal care, for example, is always as good as a regular size person's care would be, because I feel like people do judge them and people are just not interested in taking the time to provide whatever, you know, extra care they would need to.... Like let's say bathing a patient normally would take you maybe 15 minutes. With an obese patient, if you have to lift up their pannus (*panniculus*) and things like that and it requires more than one person, it's suddenly a 45-minute job. I feel like some nurses aren't willing to provide that extra time to these patients, so they just don't get it. (Nurse 5: lines 139-153)

This quote suggests that physical difficulties experienced by ICU nurses can also overlap with negative attitudes, which, in turn, impact the quality of care. The analysis revealed that nurses experienced feelings of empathy toward PLWO (as detailed in section 5.3) as well as feelings of repulsion, disgust, anger, frustration, blame, and fear. The following quote reveals that nurses may experience repulsion and disgust when providing hygiene care to PLWO:

Usually, when bariatric patients have a belly that's so large, they have a pannus that hangs over, you need three people to wash their pannus and do a good job. And you can stick your hand under and you get the willies because of how it feels and just give a quick wipe. But if you actually want to clean it properly and apply your Canesten cream so their skin doesn't break down, because most of them usually have a yeast

infection in the folds of their skin, you need two people to hold up the weight of the pannus while you're cleaning it, right. (Nurse 3: lines 239-249)

This particular quote helps us understand that feelings of repulsion and disgust originate both from the experience of providing direct physical care to PLWO in the ICU and from the construction of PLWO as “unclean” or “not as clean as the other patients.” This is important to take into account to shed light on the differentiation process that takes place in the ICU context.

Along the same lines, some nurses expressed feelings of frustration, anger and blame while providing care to PLWO in the ICU. This was particularly evident when nurses talked about PLWO not taking an active role in their own health care, lacking the motivation to help themselves during their admission in the ICU, and being “demanding” or “uncooperative.” The following quote provides evidence for this statement.

....we had to turn her in the bed.....because, yes, she had these wounds all over, trying to turn her once every two hours.....And, and she didn't like that. She wanted to be, like stay in the same position, which is what got her in the hospital in the first place. So it was a little bit frustrating... (Nurse 8: lines 93-98)

Some nurses also talked about the challenge of overcoming the pervasive social view that PLWO are responsible for their excess body weight and are to blame for their health condition. A number of participants stated that they often hear colleagues openly blaming PLWO and placing the responsibility on the “patients’ shoulders” for failing to take care of themselves and their health. According to the following participant, there is a differentiation between the PLWO who is to blame for being sick and the patient who is not to be blamed for being sick. This can lead nurses to distance themselves from PLWO and provide less nursing care. The following quote reinforces this argument:

I think there's a, there's an extreme stigma against obese patients. And I feel that most nurses just dislike caring for them. I feel that people think that these people have become fat on their own, by their own, and made that choice for themselves. And I feel like a lot of nurses that we work with just don't care and feel like they can even get away with doing less because they feel like, "Well, the patient totally doesn't care for their own body. So why should I?" For the record, this is not how I feel. (Nurse 5: lines 323-328)

Overall, nurses stated that they were more comfortable working with PLWO who are intubated and sedated because they could exercise more control over the physical body of the patient, the care provided on an ongoing basis, and the clinical monitoring required in the ICU. They were also less fearful of “something going wrong” when PLWO were intubated and sedated. Nurses voiced feelings of fear about patients repositioning themselves on their own, fear of losing intravenous access, airway access and access to other monitoring devices, and fear of patients becoming hemodynamically unstable or even going into respiratory failure because of their large abdomens. The following quote is evidence of this phenomenon:

In a shift, also, I find, if you have a more awake patient who is quite morbidly obese, who wants to help you turn them... and which is great but I find, because of the bed size and the way it's configured, they have nothing to reach to help themselves turn. So a lot of them end up kind of rolling or flopping themselves. Which that always, I'm always afraid that they're going to go over the other side of the bed when they do that. And they're being, you know, they're trying to help out. And it's not to be ungrateful... but that scares me to no end... that I'm going to lose an access or an IV line, I'm going to lose a tracheostomy or anything when they, when they get that independent, that they want to move themselves. But I mean, I have that level of stress with patients who are not obese as well when they start moving themselves, that they're going to lose an access, but it's amplified....(Nurse 7: lines 216-235)

While it should be acknowledged that ICU nurses commonly express similar fears with non-obese patients, it is important to stress that these feelings are amplified due to the physical size of the patient, the type of bariatric equipment available and accessible in ICU, as well as the increased difficulties faced by nurses when providing care to PLWO in an acute care setting.

Past negatives experiences with PLWO seemed to play an important role in shaping nurses' attitudes for two main reasons. First, negatives experiences seemed to be remembered more vividly by nurses who were interviewed.

I guess it's harder, because all the negative experiences are really the ones that, like I said, you remember the most. In the times that are more difficult are the ones that we remember, that stay with us. Especially when the outcome is negative, which happens, fairly enough in the ICU (...). (Nurse 4: lines 20-23)

Second, negative experiences can also lead to permanent changes in the way nurses view PLWO, react to PLWO, and provide care to PLWO. This was clearly and simply stated by this participant during the interview when he / she said, “In general, my experience with obese patients hasn't left me indifferent” (Nurse 4: line 271). Past experiences are among the many factors that defined what it means to “work with the Other.” Another important factor that must not go unmentioned in this section of the findings is the ICU environment itself, which contributes to positioning the PLWO as Other and impacting the way nurses provide care. Nurses who provide care to PLWO in the ICU work within a structure that has been designed for non-obese critically ill patients. This means working in “regular” size rooms with beds, nightgowns, materials, protocols, guidelines, equipment, and devices that were not intended for use with PLWO (see section 5.3 for more details). It also means viewing the PLWO as an “anomaly” in the ICU. The following section will expand on this component of the research findings.

## **5.2 Exclusionary Othering in the ICU**

Over the course of the analysis, the following sub-themes were identified: (a) protecting yourself, (b) not being able to provide care, and (c) witnessing instances of obesity bias. These sub-themes will be described separately to simplify the presentation of the findings. However, in the context of this study, it is important to understand these sub-themes as interconnected dimensions of exclusionary Othering.

### **5.2.1 Protecting Yourself**

During the interviews, all of the participants mentioned that “protecting yourself” is a priority when providing care to PLWO. When asked to expand on this particular dimension of their work, they provided examples that illustrate how and why PLWO are constructed as potential “threats” or “hazards” in the ICU. The risk of physical injuries was a constant concern among participants to a point where the need to “protect yourself” was identified as a stand-alone sub-theme during

the analysis. It was not uncommon for nurses to mention that they were fearful of hurting themselves and to stress the importance of physical safety. The following participant clearly highlights that safety is always a concern when working with PLWO to an extent that it sometimes leads nurses to being fearful and worried about “something going horribly wrong”:

If they want to get up, then I find it's a little trickier, because then you're kind of like probably trying to push more for your bed pan or something, because... Maybe and a little bit, it's like, "Oh, it's going to go horribly wrong." But then some people actually surprise you and they can get up and walk quite well.

**Okay.**

That is the fear that they wouldn't be able to.

**Okay.**

Which is there with normal patients as well, like normal or non-obese patients.... Yes. Because if they weren't able to get there to the commode or whatever, then what do you do? (Nurse 9: lines 166-179)

Feelings of fear were intensified by the risk (anticipated or real) posed by PLWO in an environment that creates limitations (i.e., access to equipment, support, physical help). They were also related to nurses being acutely aware of their own inability to assist PLWO because of physical limitations and the potential impact on the nurse's body if “something goes horribly wrong” during their shift. This previous quote also helps to show how nurses typically fear for their own safety as well as the safety of their patients, who are also at risk of physical injury during their stay in the ICU.

Nurses used various strategies to protect themselves from a potential physical injury, including what is known as “clumping” nursing care activities. The following quote shows how this strategy works by reducing the number of times nurses provide physical care to PLWO, decreasing the number of exposures to the risk of being injured, and increasing the likelihood of finding staff members to assist with direct nursing care interventions.

Got to think about your back. Got to make sure that you're not taking physically, that you're not taking on too heavy of a task on your own or with not enough help around. Their comfort level in terms of whether or not they're on the right bed. Whether we need to bring in a bariatric sized bed for them or not. Probably task orienting things as

well with them like, you know, if I've got, if I know I've got to get them washed and then might have dressings as well to do, not like you wouldn't do that with any other patient anyway, but if it was a more appropriately sized patient or like a thinner patient, you know, if you didn't manage to get to that one dressing, it's okay, I can get to it later, but with an obese patient, you probably want to clump all of the physical tasks together all at once so that, you know, you're not really, having to go over and repeat yourself so that you're taking care of your own back. (Nurse 1: lines 276-286)

The “clumping” of nursing care interventions that may have otherwise been implemented separately or at different time is a common strategy in the ICU. While some may argue this could negatively impact the quality of the care provided to PLWO, participants felt that “clumping” was their way of ensuring that care is actually provided entirely. In other words, “clumping” was described as the best balance nurses could find between providing adequate nursing care, finding other nurses to provide direct assistance, and protecting “their own back.” The next quote clearly shows that this balance is paramount when providing care to PLWO.

Physically, you're taking care of yourself. Yes, those are the really big things that come into my mind is really just taking care of, taking care of myself physically and just maybe making sure that the patient's kind of comfortable physically in their bed and making sure that their skin stays okay.... (Nurse 1: lines 291-294)

The “clumping” of nursing care interventions at specific times during a 12-hour shift was also considered essential when attempting to achieve this balance. By grouping *and* timing their interventions, nurses were physically able to provide the care needed by PLWO and do so without compromising their physical safety. These two approaches also allowed them to make the best use of the resources available to them on the unit (see section 5.4 for more details). The following quote illustrates these two points:

So, it would be a lot similar to what I normally do...except I would group it better.

**Okay.**

Like I'd be much more mindful of grouping my care.

**Okay.**

So, like assessments, assessments are more difficult with an obese patient because the bed is bigger and leaning. You're leaning a lot more into them, you have a further reach. And that I find very tiring on my back regardless because of the leaning. So I

will, I will try and do any dressings that need to be done, any care, any, anything, I will get it all done with that turn, like there will be no, I won't be sort of, I guess, I won't let myself be as disorganized or lazy if you want to call it lazy.... If it needs to be done and I've got the people, it's getting done right now. As opposed to, "Oh, I'll just, I'll just do it after." Like if it, if it requires the number of, you know, if it requires two, three, four nurses... I'll try and have everything that I have now to do it, because it may not get done next time because I may not be able to get as many staff together next time. (Nurse 2: lines 114-132)

Here, it should be noted that participants did not discuss the potential negative implications of grouping and timing their interventions. The quotes included in this section of the findings suggest that nurses are well aware that the care provided to PLWO is not “normal care” and that the way they organize the care is not “what they would normally do.” However, they also suggest that nurses’ ability to provide even the most basic nursing care depends largely on the strategic use of “clumping” to secure the necessary resources and to protect themselves.

Attempting to balance both care and safety priorities made everything seem that much “harder” for nurses in the ICU. This was particularly evident when participants talked about the experience of providing hygiene care, wound care, and comfort care, as well as the experience of assisting with routine diagnostic tests (i.e., chest x-ray) and routine procedures, as suggested by the following quote.

Everything is harder (...) It's all harder. It's all more work intensive. It's all... I mean, it's, you've got to be aware, when you lift their arm, for some of them, their arms are so heavy.... Like, you have to be more aware... yes, if you're doing a chest x-ray because you need again, you need more staff. (Nurse 2: lines 173-179)

A number of interviewees voiced that the negative perceptions of PLWO and the need to protect themselves, as well as the increased physical effort needed to take care of PLWO, can result in feelings of resentment towards this patient population. These feelings may intersect with feelings of repulsion, disgust, anger, frustration, and blame. In turn, these feelings may impact the way nurses provide care to PLWO and approach these patients in the ICU:

...of course there's comments from people to do with, worried about getting injured... when they're turning them, saying, you know, "You've made these choices. This is

the way you've lived your life. And now you want me to hurt my back turning you?"  
 ...So there's some resentment there, that kind of thing. (Nurse 10: lines 127-132)

At times, the need to “look out for oneself” may give rise to circumstances in which nurses are more aware of the risk (anticipated or real) posed by PLWO and may prefer to “step back” rather than respond to a crisis situation that could result in physical injuries.

... I don't think it did. It was... I've always been fairly careful with body mechanics and making sure I have enough people around to help. I don't think it really cared for... changed how I care for them.... I think it just made me more aware of my surroundings and maybe take a bit more of a step back say in a crisis situation, which may not be good for the patient, because I'm looking out for myself over them, but whoever... what's good for the few versus good for the many issue, right? (Nurse 3: lines 144-149)

The study findings suggest that the construction of PLWO as potential “threats” or “hazards” should be understood from the standpoint of ICU nurses who have witnessed colleagues get injured while caring for this patient population. As such, it is important to highlight that the experience of being injured or seeing colleagues injuring themselves shapes how ICU nurses view and approach PLWO. The interview conducted with the following participant revealed that nurses who get injured while providing care to PLWO in the ICU without the proper equipment and resources are profoundly impacted by that experience. This participant recalls her / his how experience of being injured:

It was an obese [patient] that had a huge dressing. And we, in holding him over for two night shifts for my body, I injured my back and for [many] years of my life and I was consumed by living my life over a back injury that was caused by an obese patient and not having the proper equipment and support to have avoided it. (Nurse 2: lines 16-20)

Physical injuries can occur at any point during the admission in the ICU, which makes nurses feel particularly at risk, and reinforces the need to protect oneself. These injuries can occur during basic nursing care such as turning and positioning, as well as during crisis situations. During certain crisis situations, like cardiac arrests, nurses may not be able to protect themselves and may get injured while attending to their professional duties. Here is one instance:

The first one that comes to mind is hurting myself.

**Okay.**

Which I think is a fairly common thing... with obese patients, whether you try to or not. Like I didn't hurt myself lifting them. I hurt myself doing CPR. (Nurse 3: lines 66-71)

Furthermore, because of the acuity, complexity, and the urgent nature of the ICU environment, the perception of being at risk for injuries can be amplified. This risk is also amplified by the lack of adequate equipment and supports (as described in section 5.3). These contextual factors need to be taken into consideration in this study, because they contribute to nurses feeling the need to protect themselves and to taking the necessary steps to limit their “exposure” to PLWO.

The interviews revealed that it is not uncommon for ICU nurses to request a change of patient assignment to limit their “exposure” to PLWO. This is often seen as the best option to minimize the risk of being injured because there are no specific measures in place to support nurses who provide care to PLWO in ICU. While this practice may negatively impact continuity of care, the following quote describes the challenges faced by ICU nurses.

But how do you cope the challenges of not hurting yourself when you're nursing an obese patient? Besides just rotating your nurses through regularly because no one can stay in that room and give the patient a continuity... a continuity of care he deserves because he's so obese. (Nurse 2: lines 459-463)

Some nurses can request a change of assignment because “they don't want to have to deal with [PLWO] for a full three days” (Nurse 5: line 337). However, participants believe that most nurses tend to request a change of assignment because of physical fatigue, fear of being injured, physical limitations related to age or physical size, career path (i.e., numbers of years left to work), illness or disability insurance or other responsibilities outside of work. The following quote supports this statement:

... for the most part, people ask to be taken off after about two days of it because your back is tired, you are tired. And none of us want to get injured.... And there's just so much that you could physically do before you start to ache. And so many of us, I mean, a lot of us are, are 15, 20, 25 years into our career, but we're 10, 15, 20 years away from the end of our career.... So I know, for me, [not being full-time] and

not having sick leave and not having disability insurance, and having a family, but yet in the back of my mind realistically I can't afford to injure myself like that again. So if I was to do a third day or whatever and I'm aching and sore, yes, no.... And I think that is, you know, I think a lot of people do feel as though they get to the point where they have to ask for a change of assignment. And I think for the most part we don't take that lightly when asking for a change of assignment. (Nurse 2: lines 477 – 491)

Although, the nurses in this study noted that attempts to protect themselves could impact the care of PLWO, they also felt strongly about the fact that these patients should be given the same patient care as any other patient in the ICU.

Me personally, the kind of care that I'm going to give to an obese patient, the level of care that I'm going to give to them really should not be any different than a non-obese patient. Like I said, I would be more concerned just with taking care of my own back, and making sure I don't hurt myself while I'm taking care of them because of the extra strain physically it's going to put on me... to have to take care of them. But, otherwise, no, I don't think there really should be any difference. It's just that I need to make sure that I, I take care of myself physically. (Nurse 1: lines 301-305)

However, providing the same patient care to PLWO is not always possible, and this may contribute to nurses viewing their patients differently and feeling differently about the care they provide.

### **5.2.2 Not Being Able to Provide Care**

When nurses talked about their experience with PLWO in the ICU, they often referred to three types of situations that made them feel differently (negatively) about the care they provided: (a) not being able to provide the same care, (b) not being able to provide care, and (c) not being able to provide quality care. Factors such as the patient's weight, anatomy, illness, condition, and acuity were identified in the interviews. Other factors such as the ICU environment, the available resources, and the priorities of the ICU were also identified as contributing to these three types of situations.

Providing the same care to PLWO as to any other patients in the ICU was not always possible. This was clearly expressed by participants when they discussed their experience with intravenous medication calculations, dosages, and protocols that are based on a "regular size" patient, central line insertion sites that are limited by the anatomy and the size of PLWO, and

standard tests that cannot be done due to the physical size of PLWO (i.e., chest x-ray post central line insertion).

Yes. So I think being turned, having, I guess, you know... basically, it would depend on what their problems are. But just being looked after like everyone else is looked after, being medicated properly, having nurses and doctors that know the appropriate amount of medications needed to make those people comfortable, you know. Often times, like, we're running a Dilaudid and Propofol drip for a 400 pounds person at the same rate that we would for a 100 pounds person. You know, and we're wondering why this obese person is grimacing, gagging, kicking, you know, and fighting us to do basic care. Well we're not maybe taking into account that they require more medication than we give our regular sized people. Things like that I guess. (Nurse 5: lines 116-125)

The participants also voiced their inability to conduct the same detailed nursing assessment when working with PLWO. Considering that nursing assessment is of utmost priority for patients admitted to the ICU, this situation was viewed negatively by nurses who often relied on partial clinical information to make decisions about their care. For example, assessing the lungs of PLWO and getting a “good” chest x-ray are often not possible in the ICU despite the fact that, in this case, the technology is available on the unit.

Auscultating lung sounds on an obese patient. Often times, you can't even hear them because they're so... Are they decreased because they have atelectasis or pneumonia? Or can you not even hear that decrease because they're so fat you can't hear through them? Taking chest x-rays because you can't get through, you can't get a good x-ray because there's so much body in the way. I mean, it goes on, and on, and on of the difficulties.... (Nurse 2: lines 655-662)

Nurses caring for the PLWO not only face significant limitations when completing their assessments but they also run into “more difficulties” when working with PLWO who require central lines – which is the case for the vast majority of PLWO who are admitted in the ICU. The following quote provides a comprehensive overview of what this entails:

Like doing lines, again, more difficult, again. You know, sometimes anatomy dictates that we can't get an *IJ* (*Intrajugular central line*) or we can't get a subclavian. Well, their groin is probably full of yeast infections. Which is where we usually slide one in if we were having difficulties, throw it in the groin. And back in the day we, we would have *TLC* (*triple lumen central*) on one side and an arterial line on the other, in their groins. On an unstable patient, we don't do that nearly as often now. But with an

obese patient it's not even a *go to* because you're going to end up with line infection because you're going through yeast to get there. So if you end up with, I mean, their subclavian (*central line*) is going to be difficult. Their necks are often so obese and short... so that's difficult. So getting the lines is riskier and more difficult and maybe the resident can't get it on, can't get it in. You know, do we call an extra staff [physician] to get it in? Does it wait until the morning? Do we run stuff, we should not be, running peripherally because we can't get a deep vein access? (Nurse 2: lines 621-645)

The experience of not being able to provide the same care to PLWO was often described as “difficult” – in the same way that patients were described as “difficult” in section 5.1.

Participants also struggled with situations in which they could not provide any care. For example, nurses often described situations where they were unable to provide hygiene care and comfort care (i.e., turning, positioning, bathing and changing linen) because they could not find anyone to help them. The following quote supports this:

Okay. I'd say probably my first obese patient in the ICU. I was fairly new and the man was alert and oriented..... He was incontinent [of stool]...and he told me. So I was like, "Okay." And I couldn't find anybody to help me. He actually sat in it for over an hour before I could get somebody to help me turn him. So it was pretty disappointing because the guy was super nice. He was very patient. And I, I kept apologizing to him. He's like, "No worries." So it was busy, mind you, the unit. But at the same time, I had paged ahead a few times and nobody ever came. And I had told the orderly, I called him and he, I think, was brushing me off. (Nurse 9: lines 22-30)

This type of situation can be partially explained by the fast-paced nature of the ICU and the fact that unstable patients are given priority over other patients who require hygiene care when resources are sparse. However, on the other hand, it is also important to acknowledge that ICU nurses can also see their ability to provide care negatively impacted by other staff members who may not be willing to help. They can also face impediments due to the lack of and limitations of the bariatric equipment available on the unit, which can contribute to nurses not being able to provide the care needed.

Participants described situations in which they were not able to provide the care needed because of the medical acuity and complexity of PLWO who are hemodynamically unstable. The

following quote provides insight into the ICU context as well as the complicated decision-making that nurses face when they have to complete even the most basic nursing care. It also emphasizes that providing or not providing hygiene care, for example, is a complex decision when working with PLWO, because, unlike “other patients,” they can decompensate quickly when they are turned in the bed.

... So yes one night, one night we had a, a, a very obese patient. And he had a [tracheostomy]..... had been with us quite some time having respiratory difficulties. Having trouble breathing and had soiled the bed. Like soiled most of the bed and was beyond being able to just leave him in it. And he had arrested, he had a respiratory arrest and then a cardiac arrest because it was just... I don't think it would have necessarily happened had he not, had we been able to change him in another way. Like sometimes we can at least lift a leg and clean one side and lift another leg and clean the other side and get a large portion of it cleaned that way and then quickly flip one way, flip the other way, get a whisk on it at least. It's better. But you can't do that with obese patients. You just can't. There's too much of them in the bed, like...And that's what happened like he just arrested because we couldn't... find another way around having to change it out..... And I don't think anybody foresaw that he would ever arrest. For sure. We thought, "Okay, well, you know, we'll probably have to put him back at 100%, you know, make sure the RT is close by." You know, "We'll do this as quick as possible." Nobody could ever foresaw it. We suspected he would desaturate. Maybe require some good suctioning, bagging or something like that...and there was big there was some discussion on how to...best attempt this. But he arrested. (Nurse 2: lines 541–584)

Similar situations were described by other participants – situations in which “normal” care such as turning and positioning was put on hold to prevent the patient from decompensating and potentially from dying. The following quote supports this:

His blood pressure was actually quite low. We had a hard time with medications, keeping his blood pressure, at a normal level. And like I said, because of his size, having venous central access was a problem. Getting the medication, getting a, a good medication delivery to him was problematic because the, the doctors had a hard time getting the IV access. (...) And being hemodynamically unstable, we couldn't move the patient very well. And him being, large or morbidly obese, any little movement seemed to kind of compound our, our inability to, I guess, keep him hemodynamically stable. (Nurse 4: lines 34-42)

In order to clearly explain the types of situations that they face when they provide care to PLWO, participants would often refer to “non-obese patients” to describe what “normal care”

looks like in the ICU. This differentiation process was deemed essential to explain why nurses were not able to provide care in certain situations.

Patients who are not obese sometimes are able to do small movements to try and, and help take pressure off certain areas in the body. But however, this man was so large, we couldn't even move a little bit of him, to kind of alleviate some of the pressure points...because he was so big...any little movement would, would decrease his blood pressure. So we couldn't change his sheets, we couldn't turn him... so it was really hard to do basic hygiene care as well since, it was difficult to, to reach some of the, the vital parts or the private parts to, to maintain any kind of hygiene care. (Nurse 4: lines 47-53)

In the same way that nurses faced situations where they could not provide hygiene care or reposition a patient, they were also faced with situations where they were unable to do life-saving interventions such as cardiopulmonary resuscitation (CPR):

You couldn't get up to do effective chest compressions. And you couldn't get on the bed, because he was wider than the bed was. Because he wasn't in a bariatric bed, it was in use. (Nurse 3: lines 170-174)

Participants were often confronted with situations where they were not able to provide quality care to PLWO. When compared to the care they “normally” provide to other ICU patients, participants considered that PLWO did not get turned as much and did not get the same kind of skin care. The following quotes highlight this:

So the ceiling lifts we have can help turn these, patients. If you don't, then you have to call four or five other people to your room every time you want to turn them... so they, they don't get turned as often. They don't get the same kind of skin care... so that's, that's difficult. (Nurse 10: lines 191 – 194)

I guess like turning is just as important with obese patients as it is with non-obese patients. And I feel like we don't do our Q2 (*every 2 hour*) turns with obese patients like we do with our non-obese patients because they're so big. I don't think that's an appropriate rationale. I don't think weight makes you not need to be turned every two hours. In fact, I think it's more important because there's more pressure around certain areas when you're larger. (Nurse 5: lines 108-113)

Furthermore, PLWO did not receive the same quality of care when undergoing diagnostic tests like x-rays and ultrasounds. For instance, this participant explains,

Medically, tests are always difficult, because when you're in the ICU and you've got somebody that's overweight, they always want to check the lungs with a chest X-ray and, with all the tissue in between... the x-ray machine and the plate... you never, you rarely get a good chest X-ray. For other tests, like a transthoracic echo or even a transesophageal echo, the transthoracic a lot of them aren't good because there's too much tissue in the way. You don't get a proper picture. And even with the transesophageal ones, you can't always get them positioned enough on their left side in order for them positioned properly in order to get a good picture from that... they don't fit in any, or at least the morbidly obese patients don't fit in any of the scanners outside the unit. (Nurse 3: lines 271-285)

Additionally, quality of care was negatively impacted because diagnostic tests (i.e., computed tomography or CT scan) could not be done even though they were medically indicated.

I've had a patient that probably had pulmonary embolisms everywhere, but she was so large we couldn't actually scan her. So that's something that's kind of....

**So what other challenges came about because you couldn't scan her properly?**

We had no idea why she was doing so poorly. It was just a theory. Like, because she did possibly have a clot in her leg, which also was hard to see because of the visualization, because of how big she was. So we were just treating her without confirmation, which is not, isn't necessarily a bad thing. But, I was so busy with her because she was just getting worse, and worse, and worse. And, and like although our interventions, like an echocardiogram, you know, nothing could tell us like... because it was so hard to visually see, it was, it just, it was technically difficult. (Nurse 11: lines 161-174)

A number of participants mentioned that quality of care was also impacted by the lack of clinical information specific to PLWO. For example, the lack of guidelines or protocols for intravenous medications that are used to sedate patients who are mechanically ventilated can result in less than optimal clinical situations.

When I came on shift, like he wasn't sedated properly and he was thrashing around in the bed and it was because the doses that we had to use for this person were so high that the residents, especially at nights, were kind of hesitant to order doses that high. So I came on and this person wasn't sedated properly and they were ventilated, they were thrashing. And I thought, you know like, "If this guy falls out of bed, how are we going to get him back into bed?" Our lift can't really lift over seven hundred pounds straight up off the floor. People can't really do that either. So plus it's a danger to him. And if he extubates himself on his way down, like what are we going to do, you know? So it was a really dangerous situation. And like we ended up giving him a lot of medication. And it was, like way more than we would normally give to a person and I just, you know, I had to sign for these high, high doses, but that's what the doctor ordered but it just... I don't know. (Nurse 6: lines 54-71)

The analysis revealed that nurses face numerous questions and a great deal of unknowns when they provide care to PLWO in the ICU. This is largely due to the fact that the environment, the care, the tests, and the treatments are designed for “non-obese patients.” During one of the interviews, one participant went on to highlight how this impacts the quality of the care and how nurses feel about the care they provide to PLWO: “I think I just feel like I'm on the edge of having provided that patient with safe care” (Nurse 7: line 174). Another participant described feelings of inadequacy for not being able to provide quality nursing care to a PLWO.

So, physically... so pressure points, skin care, would be the major, the major concerns for me. I guess one of the other aspects too is the, is the, the emotional, the emotional part of nursing obese patients. It's hard to tell somebody some times, "Well, I'm not strong enough to help you right now. I need to get more help."... sometimes I find that, is difficult for me as a nurse, but... an individual nurse saying, "You're too big." "I can't do it on my own." In the ICU, I find it a little... it's different because the, the resources and the help is more available... but sometimes, when the resources or the, the help is not available, you almost kind of feel inadequate. (Nurse 4: lines 109-114)

These feelings are important to acknowledge, because nurses are regularly confronted with situations where they are not able to provide PLWO with “the care that they should be getting” (Nurse 9: line 109).

### **5.2.3 Witnessing Instances of Obesity Bias**

In this section, the goal is to focus on “instances of obesity bias,” or, in other words, instances when participants were challenged by their own past (negative) experiences with PLWO as well as instances when their patient was the target of derogatory comments and jokes, negative attitudes and behaviours, and inappropriate conversations. However, it is important to point out that many nurses were able to overcome these instances of obesity biases and challenge their own reactions as well as those of their colleagues. The inclusionary strategies used by nurses to achieve this will be described in section 5.3.

During the interviews, it became evident that nurses were not only challenged physically when they provided care to PLWO but they were also challenged by their own past experiences as well as their experiences with colleagues who displayed negative and discriminatory attitudes towards PLWO – the same colleagues who nurses rely on to help with nursing care interventions and direct physical care when they work with PLWO. Thus, it is not uncommon for nurses to react negatively when they start a shift and find out that they have been assigned a PLWO.

So, like, whenever you start the shift, if you find out that you...once you find out you're looking after somebody who's obese or morbid... I'm assuming we're talking about like morbidly obese people.

**In part, yes.**

You sigh. And I know that sounds terrible, but you do.

**Okay.**

Because it's a lot of work and it's a lot of... there are a lot of societal preconceptions that go along with it that are very hard to escape, because they're also thrown at you by your co-workers as you get there. (Nurse 3: lines 13-21)

During the interviews, participants acknowledged that past negative experiences can have an impact on the way nurses approach PLWO and attend to their care. The following quote explains how negative experiences, even if these experiences may occur very infrequently, can impact the way nurses approach PLWO. It is almost as if these experiences are “carried over” to other PLWO, days, weeks, and months later.

And I feel, because we don't get them that often, I feel that there is a tendency to relate their experience with one obese patient onto another obese patient. For example, if they happened to have an obese cranky patient three months ago and then, you know, they're now assigned a second obese patient, I think because there's been, you know, a while since they've cared for this type of patient, there seems to be a tendency towards trending one person's condition and personality on to another. So you know, they automatically may assume like, "Oh, this patient's going to be cranky and not appreciative. And why should I go above and beyond — you know — what's expected of me to look after this person when the last time I looked after an obese patient, they told me to screw off and get out of the room?" You know, so I feel like that's not done as much when we care for regular sized people because most of our patients are regular sized. But when they're obese we don't see them as

often and I think it stays, a nurse's experience with that type of patient, it stays in her mind or his mind and then it's carried over, over to the other person that they care for that's like that. (Nurse 5: lines 203-306)

As suggested by this participant, the phenomenon of “carrying past negatives experiences over” to other patients seemed to be more common with “obese people” versus “regular sized people.” In light of the findings presented above, this phenomenon seems to indicate that obesity bias takes many different forms in the ICU context and that it can also be intensified when nurses are challenged both physically, mentally, personally, and emotionally in certain care situations. Additionally, many nurses mentioned how they were better able to remember the negative experiences of providing care to PLWO more vividly than the positive experiences. This is consistent with observations made during the interviews. When asked to comment about their experience of providing care to PLWO, participants would automatically refer to negative experiences.

Negative experiences provided by participants almost always included multiple and repeated “instances of obesity bias.” Witnessing these instances of obesity bias was considered to be a significant challenge when providing care to PLWO. For instance, one participant acknowledged that “dealing with the negative comments from your co-worker next to you is challenging through a 12-hour shift” (Nurse 10: lines 175-176). Examples of obesity bias from colleagues included derogatory jokes and comments, negative attitudes and behaviours, and inappropriate conversations. One participant stated,

I find that there's a lot of chitter chatter that goes on in the break room and stuff when we have obese patients about, you know, just nurse chat. And maybe it's a way for nurses to relieve stress or to debrief on having to look after these enormous people. But I find there's a lot of gossip when we have these big people in the ICU, "Oh my God, this person weighs 600 pounds. Did you see him? Walk by his room later." You know, there's this inappropriate chitchat that goes on. (Nurse 5: lines 264-269)

As mentioned by this participant, instances of obesity bias frequently took place outside workspace and during break periods. When these types of situations were mentioned in the interviews, they

were often described as “inappropriate” but serving some kind of purpose. That is, they allowed nurses to “vent,” to acknowledge the actual physical size and weight of the patient, and to get validation for the work they were doing, often with very limited or no support.

Absolutely, I think, you know, they just want justification that maybe, "Yes, you're doing a good job, you know, caring for this 650 pound patient today or doing the best that you can. I saw how huge he was. I get why you're having a stressful day." You know, I feel these nurses come into the break room totally dishevelled, flabbergasted, frustrated. And they're either just seeking validation from their peers that it's okay that they feel frustrated, that they feel tired, that, you know, they don't feel like they're being supported in the way that they need to be. (Nurse 5: lines 278-284)

Other, more extreme situations were also described during the interviews. For example, some participants described instances where they witnessed colleagues behaving inappropriately and unprofessionally with PLWO. The following quote depicts one of these situations:

Another negative experience I've had with one of the patients... she was a morbidly obese patient. And I picked up after the [previous] nurse. And I was there during the day. And while the [previous] nurse was giving me report, she said that... The [previous] nurse had had a conversation with this patient and because she was on the ventilator, she couldn't speak, but she's still quite awake. We were pretty close to extubating her. I guess the, the [previous] nurse had had a conversation with this lady and [made a comment], quite bluntly and in a very negative way.... And I guess the patient had been very upset with that. And when I came in, like I could see she was still teary, she had red eyes, that, that... the night nurse had made her cry. And, to me, that is, it's insulting. (Nurse 4: lines 291-301)

These situations were difficult for nurses because “shutting down” a colleague who is behaving inappropriately and unprofessionally is not easy. As this next participant points out, nurses who face these difficult situations will try to control what is taking place in their room (i.e., the room of their patient), but they may not feel confident enough to pursue this outside the room.

I'm still not, I don't know, confident enough to shut down one of my colleagues who's going on about that... because it's hard to rock the boat (...) And so I'm not going to go there and try and shut someone's mechanism for whatever, that person might use the humour as their coping like mechanism I guess... by shutting it down.... I will shut it down though in my room, like...No question...But outside of the room or in the break room... I just ignore. (Nurse 7: lines 1010-1027)

Nurses may also find it difficult to “shut down” colleagues due to fears of repercussions, including colleagues refusing to help or being less willing to help with physical care.

Witnessing instances of obesity bias from colleagues made them question the quality of the care provided and the differential treatment of PLWO. While it was difficult for nurses to determine if the care was negatively impacted, they often wondered if this was indeed the case.

I can't comment on that because, you know, when I've, when I've picked up after, you know, to look after an obese patient from another nurse, it's difficult to know if the patient has been well physically looked after or not. I mean, you can look at the chart and see that they've received all their meds, if the nurse has documented that they've turned, if they've been stable or unstable. So medically wise, you can see if they've been cared for or not (...) But I mean, certainly, from what you hear, you know, the gossip that you hear, even just getting a report from the nurse, like, "Oh, poor you, you're going to have one hell of a night. He's humongous." You know what I mean? Like comments like that make you wonder, "Did this patient really get the care that, you know, our 150-pound patients would get?" (Nurse 5: lines 345-365)

During the interviews, participants reflected on the way colleagues “talk” about PLWO when they perform routine care activities and how this can negatively impact the patient even if this patient is sedated. The following quote was selected because it makes a particular point of considering the impact of derogatory comments and jokes on patients who are awake *and* on those who are sedated.

It definitely affected my practice in terms of like I noticed a lot of nurses, like how they talk about bariatric patients. And like how they make it such a big deal, like in terms of, you know, if they have to turn a patient, they announce it overhead, you know, "Five nurses needed for a turn." And I find it so inappropriate. I'm like... you know, even when patients are intubated, but they may not be sedated and like they could still be aware, they're like, you know, make grunting noises or, "Oh wow! This guy is big, oh my God! How much does this person weigh? Holy crap! Ow, it's hard to turn." And I'm just like, "What if you, what if you're in bed, can't say anything, can't speak for yourself and you're hearing people talk about how, you know, overweight you are." (Nurse 11: lines 83-95)

Along the same lines, the influence of bedside communication, in the form of a bedside shift report between nurses, arose during the data analysis. Here, it is important to point out that shift report is done *at the bedside* in the ICU and not at the nursing station, as happens in other units

in the hospital. At the start of a shift, nurses have to deal with their own past experiences with PLWO and preconceptions about what their shift will look like, experiences and preconceptions that, in and of themselves, present a challenge. Nurses are further challenged by bedside communication during shift report.

The analysis revealed that shift report can “frame” the nurse–patient relationship in a negative way, whether the patient is a PLWO or not. In fact, the bedside shift report can result in nurses “passing on” exclusionary views of the patient to the following nurse. The following quote demonstrates this point:

I'm even guilty of that. Whether it's an obese patient or not, you know, if you get a report from a nurse that's had a bad day with a patient for whatever reason, if they start their report by saying to you, "You're going to have a horrible night or day because X, Y and Z happened on my shift," it's hard for me, you know, to then look at my patient with a clean slate and think, "Well, you know what? It's a new 12 hours. My day might not have to be so bad." But when that's given to you right away and you're sitting down, ready to take over the care of this patient, you're automatically set up with a negative, you know, image or, you know, with a negative framework to work from. So it's difficult to get away from that. (Nurse 5: lines 369-377)

In the context of this study, it is important to keep in mind that exclusionary views of PLWO can be “picked up” during shift report, meaning that these views may or may not be present prior to the report. In this sense, obesity bias during shift report can perpetuate negative views of the PLWO from one shift to another.

I had to take care of a 25 year-old man.... He weighed over 600 pounds. And, initially going in, hearing his age and then hearing how big he was, like initially, I thought, “Oh, this is horrible, like, this poor kid, he’s only just starting and already he’s like got this huge, almost disability about his life now.” And you wonder like, “Man, he must be really lazy at home or he must be....” Yes, people... like he must have lots of enablers around him or... You know what I mean? It just.... And I had more of a, hearing his initial story from the nurse on, on shift change, I had a more of a negatively attached view of who he was. (Nurse 1: lines 39-46)

Participants also explained that a “negative report” at change of shift is often linked to nurses leaving their shift “feeling a bit frustrated” or “exasperated” after providing care to PLWO for 12 hours (Nurse 7: lines 814, 821, 827). As one participant stated, this “makes it difficult to start your

shift on a positive note” (Nurse 3: line 27). Nevertheless, the analysis revealed that nurses use different inclusionary strategies to make sure the “negative report” does not take over their shift. These strategies are described in the next section.

### **5.3 Inclusionary Othering in the ICU**

Over the course of the analysis, the following inclusionary practices were identified: (a) keeping your distance, (b) getting to know your patient, and (c) role taking. These practices were described by participants as they talked about strategies used to provide care to PLWO while emphasizing ways to work “productively”, that is, to work in ways that make a positive difference with this patient population and to make the ways they work a focus of the care experience. However, in the context of this study, it is important to understand these inclusionary practices along with how PLWO are identified as Other and the resulting exclusionary practices which have been presented in section 5.2.

#### **5.3.1 Keeping Your Distance**

During the interviews, participants described their efforts to remain distanced from the “negative end of shift report” described in section 5.2.3. Nurses described “keeping their distance” from the negative comments that were made during the shift report in order to remain “impartial” and “professional.” Nurses also described keeping their distance from instances of obesity bias that take place throughout the 12-hour shift. Nurses attempted to keep their distance by approaching PLWO with a “clean slate” and by getting to know their patients (see section 5.3.2).

Yes, well, it's kind of... I took away from it something that I usually take away from a patient where I get a report where I feel like my day is going to go horribly wrong with a patient and I'm going to butt heads all day and then it turns out that they are actually a really nice patient. And regardless of whether or not they're obese, really, it's for... this really is kind of for any patient that, you know, gets a bad rap on my initial report from like the next nurse... from the previous nurse.... And it really, it, it's, it teaches me that, and it teaches me that, it reminds me this all the time when I have a case like this, but, obviously, it's usually no more evident in an obese patient

because that's something you can see right away, that, I really need to walk in with, I need to walk into any case with a clear head and to give my patient a complete clean slate on who I think they are, and how I'm going to perceive them. And that regardless of what they look like, who they might be, that they deserve the same care as everybody else. But, yes, the biggest thing is usually that, you know, I really can't judge somebody based on somebody else's story of them or from an initial look at who, like, like that, like I need to figure out who this person is before I can make a clear judgement on who they are as a person. (Nurse 1: lines 123-137)

In addition to approaching the patient with a “clean slate,” participants tried not to listen to other nurses, or, as one participant explained, tried to let the information that was not relevant to the care of the patient just “wash away.”

I sort of... I don't really listen to people.

**Okay. (Laughs). Okay.**

No, (Laughs), I listen to report, but I really, I'm... I, I don't internalize everything that is said to me in report, I guess that's what I want to say. I pick out what I feel is relevant and just let the rest wash away. So I don't go in, I mean even though you say I don't go in with a preconceived, you know, expectation of my patient, they make sure I've heard it and I've heard a lot of, "They don't want to do anything" or "This patient is combative" or what. But I actually love proving people wrong. So I try and go in pretty neutrally, but, certainly, reports can influence people and how their approach is with a patient, absolutely. (Nurse 7: lines 887-900)

This particular quote suggests that some nurses make a conscious and active effort to let the information “wash away” and to not internalize the information, so they can remain impartial when assigned to a PLWO.

Interestingly, participants described how, by keeping their distance, they were able to positively re-frame the nurse–patient relationship in a positive way, and used end-of-shift report to “pass this on” to the next nurse. This process parallels what section 5.2.3 discovered about nurses who may “pass on” exclusionary views of the patient, though the outcomes are quite different. From this distancing perspective, end-of-shift report was seen as an opportunity to actively oppose the obesity bias and provide a buffer from the views of the oncoming nurse. The following quote describes what this inclusionary practice entails:

Actually, I can think of when I would have given report on, the [patient] that I took care of, my one nurse came in to relieve me on a day shift I was coming off the night shift. And he took one look at the room and went, “Oh, really I’m going to have this kind of a day?” And I looked at him and I went, “Oh no, not at all. He’s a really good guy. You’re going to have a really good day.”...hoping that maybe that turned, might have turned things around for the way he was seeing it, because then I felt that his picture really was not... or the way that he reacted to just seeing him in the window, I was hoping that... well, you could tell just by looking at him that that was the impression he was going to get. But, hopefully, with my tone of voice and sharing a bit more of my experience with him, it would have given him a way better idea of actually who this patient is and not just who he thinks he might be from what he looks like. (Nurse 1: lines 106-117)

Attempts to positively re-frame the nurse–patient relationship were often combined with other inclusionary practices, such as keeping a distance from personal views on obesity (i.e., obesity as an outcome of someone eating too much). In order to achieve this, some of the participants explained that they intentionally draw on clinical and scientific understandings of obesity when talking to colleagues. The following quote describes how this works as an inclusionary practice:

I don't like being told what to do. So when I see people, choosing a group and, you know, insulting them or, you know, all of these things, if anything, it makes you want to look at things another way. And I have on occasion in the lounge... kind of offered another opinion. For example, if someone's talking about someone who's eating too much or whatever, I have on occasion brought up some of the science that we don't understand... with regards to these patients... so if anything, it pushes me to consider this issue, more deeply and to be more conscious of how I act around these patients. (Nurse 10: lines 145-155)

Participants also tried to keep a distance from “societal judgments” related to obesity, which implied that they had to “put aside” their own attitudes, ideas, opinions, values, and so forth. This was considered to be challenging for nurses who provided care to PLWO in the ICU:

Challenging.... challenging physically, and challenging mentally in terms of, how I perceive my client in an overall sense.... you know, trying to put aside, I’d say the biggest part is trying to put aside societal judgments or the stigmas that society puts on the obese population and trying to, yes, put that to rest so that I can go in and take care of my patient as who they are as an individual and not with the stigmas attached to them. I’d say, yes, and the physical part is probably the biggest challenge that I have, but... And, actually, oh yes, that’s probably it. It’s just it’s a bit of a challenge in terms of physically and mentally, how I, how I perceive them and how I have to work around their, their condition in order to take care of them. (Nurse 1: lines 5-13)

The analysis revealed that “leaving these judgements at the door before going into the patient’s room” is challenging for nurses who work in the ICU because they are not immune to negative societal perceptions of obesity. The following quotes support this:

Yes and then maybe we’d be able as nurses to be not so, like hard on them for being obese. Because, like I said, that stigma still comes into play I think initially when you’re taking care of somebody. And before you really get to know who the patient is they’ll still come into play. I just know from my personal experience that, I do my best to leave those stigmas at the door...Before I go into the patient’s room. (Nurse 1: lines 383-387)

But I try to think these people are people underneath it all as well. So I try not to, to treat them any other way than... try and treat them the same as everybody else. But we’re still, we’re still people. (Nurse 4: lines 276-278)

Participants acknowledged that keeping one’s distance had its own limitations because “nurses are people.” In other words, nurses internalize the same negative societal perceptions as other people in society do. Yet, they felt it was important for them to keep a distance as much as possible from these perceptions in order to maintain a professional stance and “look after PLWO the way you are supposed to.” The next quote supports the idea of maintaining a professional stance when providing care to PLWO.

And you know, as a nurse, you’re not supposed to have any preconceived notions about why a patient is the way they are and how they got there, whatever. You’re supposed to just look after them and care for them and... and that’s what you’re supposed to do. So I try to do that. (Nurse 3: lines 58-61)

### **5.3.2 Getting to Know the Patient**

In addition to keeping their distance, participants made a conscious effort of “getting to know their patients” on a personal level. This inclusionary practice required nurses to approach PLWO with a “clean slate” and establish a connection with the patient as a person. Getting to know the patient was essentially described as a way for ICU nurses to look past physical appearance and to connect with the patient on a personal or human level.

But I try with every patient just to look them in the eyes and see them for who they are and, and try to make some kind of connection and just not see all the extra adipose tissue and just see who's in the bed or not see the ventilator or the central line, and just kind of deal with people on a human level. (Nurse 10: lines 176-179)

During the analysis, it became apparent that it was easier for nurses to get to know their patients if some form of communication could be established: for example, if intubated patients were able to communicate through writing or if patients were not intubated and were able to communicate verbally. The following quote supports this finding:

Even though he was intubated, he was fairly awake and able to communicate with me. And, yes, his personality came through despite the fact that you're communicating with like a writing board. But still, I could see who... I could see what he was watching on TV, we chatted a bit about like some of his sport interests. And, yes, and like when I had to do really personal things with him, you could see in him that like he was embarrassed. Like I had to give him a bed bath and he was embarrassed that I was giving him a bed bath. And he said, he, he actually, he wrote, "I'm really sorry about this" when I gave him a bed bath. And it was like, "Sorry for what? Like this is, this is my job. And you need to, you know, I need to help you to get washed up right now because you're not in a place to be doing it." And it was like, yes, at that moment, any, I could understand where he would be saying, you know, "Sorry about this," because, it is, it was harder work for me to have to clean him because he was so much bigger. But that, you know, that, that didn't matter. I had to do my, I had to do my job. And he needed help in that moment. And regardless of, his size, or what predisposed him to be that size or what anybody else thinks of him just by looking at him, it didn't matter anymore. He was somebody who needed help. And at the basis, that's really all that we should really think about when we're going in and taking care of somebody... which is why I was really glad that I could talk to him and that I could, get to know who he was because, yes, it totally brushed away the thoughts that I had when I came on shift that day of... Yes, it completely changed my perception of who he was as a person. (Nurse 1: lines 46-68)

The ability to connect with the patient through different forms of communication is not always possible in the ICU context. Since the majority of PLWO are intubated and sedated in the ICU, nurses may not be able to get to know their patients. This is important to consider, because it may limit the use of this inclusionary practice by ICU nurses and, in some way, contribute to the depersonalization and dehumanization of PLWO.

In situations where nurses were unable to get to know the patient because that patient was unable to respond, speak, interact, or communicate in writing, they considered that getting

to know the patient through the family was another way to see past their own attitudes, ideas, opinions, values, and so forth. The next quote emphasizes the importance of this strategy.

The easiest case for me to get over that is if I have a patient that, is cognitively aware and able to communicate with me... because the minute I get to talk to a patient and, for some reason for me, the minute they have a voice, they become an individual and all of those stigmas kind of do float away and you get to know the patient for who they are and who they are as a person, their personalities, their own quirks and characteristics as opposed to kind of what you're seeing from the doorway, which is obviously just an obese patient as soon as you kind of look at them. Once you go in and kind of get to talk to them and get a feel for who they are, the whole, for me, the whole thing changes. If it's somebody that isn't able to respond to me, I'll try my best, once a family member comes in to visit to maybe learn a little bit more about them and who they were, who they are at home so that it takes, it takes who they are for as my patient, into a more personal level and not quite so vague where I feel like the... the societal stereotypes can attach more easily. (Nurse 1: lines 20-35)

The ability to connect with the patient through the family may be encumbered if family members are (a) not present, (b) do not want to provide insight into the personal life of the patient, or (c) do not view the patient in a positive way. Establishing a connection with the family can also help nurses understand the life story of the patient and his / her personal struggles outside of the ICU context. One participant was able to articulate how this connection can impact the way ICU nurses approach the overall care situation.

And talking about how they told him that he needed to lose weight and it's been a real struggle for him for his whole life. And his mother was crying at one point because, she was recalling like stories from his childhood. He would be bullied because he was overweight. And it was really, that was tough. And that was mentally tough for me and for the family as well.... (Nurse 8: lines 179-187)

Getting to know the patient on a personal level included getting to know the story of that person. Getting to know that story was challenging at times for ICU nurses.

Because, you know, they've all been through different, you know, he suffered from mental illness and depression, and all sorts of different things. So not to judge people and automatically think that they just did it to themselves. Like they, they... everyone has a story. So not to just think that they're just this fat person in bed that, you know, can't take care of themselves. (Nurse 11: lines 76-81)

Participants recognized that the idea of establishing some sort of personal connection had its own limitations, because the patient may exhibit an undesirable characteristic (i.e., being depressed or unpleasant) or may fit a certain stereotype (i.e., lacking motivation). When this is the case, it can be harder for nurses to connect with the patient as a person. During the analysis, it was noted that ICU nurses tend to connect more easily with PLWO who comply with medical advice, acknowledge that they have a problem and make an effort to correct it. Nurses would view these patients as persons with whom it is easier to relate and who are easier to get to know on a personal level.

Yes, actually, there was one guy that I was looking after who was [over 600] pounds. And he was young. And at least, he was a very positive guy to begin with which helps because most of these patients are not. Most of them are angry, or depressed, or they're frustrated, or lazy. It sounds terrible to say, but they are... they don't want to, they don't want to do anything, right. If you've gotten so fat that you ended up in the ICU, and it's from lack of... whatever causes a lack of willpower to do anything to change or take care of yourself or look after yourself, you're usually not a happy person to begin with. But this one guy, he was pretty happy and he had a lot of good familial support, and I looked over... I looked after him over the time period of when he was intubated to extubated. So being able to see him get extubated, not having any issues and having him be able to get up on his own, and want to do things... that was positive. So... because he also, what was stated to me, recognized that what had happened to him had become a problem. And that he was willing to take steps to fix the problem. So that was pretty positive. (Nurse 3: lines 115-135)

This quote demonstrates how inclusionary practices may be seen more favourably and may be more easily implemented when PLWO adopt the recommended approach to viewing and addressing their health situation: being positive, happy, goal-oriented, and compliant. Unsurprisingly, then, these practices may not be used as frequently, or may not have the same impact, when PLWO are seen as negative, difficult, noncompliant, depressed, and lazy.

### **5.3.3 Role Taking**

“Role taking” was another inclusionary practice described by participants to foster a human connection with PLWO and to acknowledge their point of view. Participants often reflected on how they would feel if they were in the same position as their patients, and commented on this role-taking process during the interviews.

Because we had to use like eight people to get him turned, to hold him over and to wash him up, and obviously they figured, "That's not a priority for us, let's just get him over to the other hospital." Which thankfully this patient was sedated and like didn't know anything that was going on, but I think if that were to have happened to me, to think that somebody put my, my sanitary conditions, like my cleanliness as a low priority because of my size, I'd be hurt and I would feel very much, less, I guess, like, well, less human. (Nurse 1: lines 154-160)

Role taking was used as a gateway to understanding and providing compassionate nursing care that is patient-centred. The ability to role take was influenced by a number of factors including, but not limited to, how well the nurse could relate to the PLWO and their condition and how much personal understanding was available to the nurse regarding the challenges faced by PLWO. The following quote demonstrates the importance of nurses feeling that they can relate in some (human) way.

When I took care of that young patient, there was so many like if... you know, luckily, lucky for him, he doesn't have a ton of health issues despite his size. But just him telling me, you know, what he would do if things were different and all the like travelling he would do, and what he would want to be, and all the stuff, and just to have weight as the only... reason why he can't do these things and live, actually just live. Like he doesn't even have a life right now. It's really sad; it made me really sad. Especially like, because we're the same age and I can't relate to him, like, because... I, I can't imagine being like that. (Nurse 11: lines 427-411)

A number of participants explained how they were able to draw from their own personal experiences with family members who are obese to facilitate role taking.

[One of my family members] is quite overweight. And he's obese. And so I feel like, I guess this is where things get tricky, I don't want to, I don't, I feel like as a nurse, I don't want to blow the line between sympathy and compassion. Because I feel like sympathy can sometimes turn into a negative approach to things... and so I did feel a bit sympathetic for him, because of my [family member]. But I also feel like it gave me, like, I don't know, kind of gave me an up, in speaking with the family because I do have personal experience with it. So I kind of drew upon those [experiences]. (Nurse 8: lines 199- 218)

The previous quote illustrates how role taking, as an inclusionary practice, creates a personal connection between the nurse and the patient. However, role taking is also challenging and may not be practical for nurses who struggle to see the situation through the eyes of their patient, nurses who hold strong negative views toward obesity, nurses who cannot begin to

understand how the patient has arrived at this point in their life, or nurses who have no personal understanding of what this experience might look like. Some participants mentioned that it was difficult for them to role take, or, as one participant stated, “to kind of put myself in their shoes and how like if I was that size, how I'd want to be treated” (Nurse 11: lines 451-451). The challenging process of role taking or “trying to put yourself in someone else’s shoes” was also acknowledged by another participant.

Yes, so, emotional support sometimes is difficult... because it's, it's hard to empathize sometimes... Because it's hard to get into somebody's... an obese patient's shoes. I'm very small and I have no idea what they go through... and I can, I can listen to the problems, but it's hard sometimes to try and, and direct a conversation with them, because, like I said, I can't put myself in their shoes sometimes. I don't, I don't know what they go through. I don't know what they, what they're living every day... sometimes it's hard too because you know it's a physiological problem and they can't, they can't do anything about it.... It's a little bit hard when it's lifestyle and I know I wouldn't chose that kind of lifestyle. So it's hard for me some times to understand why somebody would choose a lifestyle that would lead them to being so obese.... Sometimes, it's just... yes, it's hard to, for me, to understand what the rationale is behind their, their lifestyle...so it's hard to, to give support sometimes that way, but I always try and listen if I can listen. (Nurse 4: lines 134-155)

As suggested by this participant, it was particularly difficult for nurses to role take when they viewed obesity as a result of bad choices, unhealthy behaviours, lack of motivation, and sedentary lifestyle. Nurses also emphasized how hard it was for them to “understand what PLWO are going through” because they have a hard time relating to their situation.

And it's hard sometimes not to judge, like I said earlier, especially when it's a lifestyle choice... I guess I, I try hard to, to stay healthy and, and, and eat well, but I have to say I've been lucky with a fast metabolism... so it's hard sometimes to get in the shoes or get in an obese patient's mind, try, really try to understand what they're going through. And I think that's the hardest part. (Nurse 4: lines 282-288)

#### **5.4 ICU Environment**

The ICU environment has a number of resources available to assist nurses in caring for PLWO. The analysis revealed that these resources vary from one unit to another, and can be divided into three categories: physical resources, informational resources and human resources. These

resources can positively or negatively impact the experiences of nurses working with PLWO and the way nurses work with each other in the ICU context. The analysis also revealed that nurses perceive a lack of resources, and they have clinical, informational, practical, and organizational needs regarding the care of PLWO.

#### **5.4.1 Resources**

The majority of participants had similar responses to what *physical resources* are available to them in the ICU environment. Nurses stated that the rooms in the ICU are bigger to allow them to have more persons and equipment in the room to help. There are ceiling lifts in most patient rooms, and there are portable lifts present on the unit if a ceiling lift is not present in the patient's room. There are special beds, called bariatric beds, which have special mattresses to diminish skin breakdown. In addition to beds and lifts, there are weight specific slings for the ceiling lifts, bariatric walkers, wheelchairs, and commodes, as well as a bariatric bench chair. These units also have stools for nurses to access bariatric beds to complete basic nursing tasks such as giving medications and patient assessments. Nurses spoke of these resources as essential to the care of the PLWO as well as their ability to decrease the number of persons needed to turn and reposition, bathe and mobilize the patient. For further information on the equipment and a full description of the research context, see Chapter 4.

A number of nurses identified that ICU physical resources and even basic necessities, such as patient gowns, are not always easily accessible or available. This lack of accessibility or availability can affect the experiences of nurses caring for PLWO as well as the patient's experience of being hospitalized in the ICU. In addition, it can negatively impact the quality of nursing care and can create situations in which nurses are unable to uphold their professional standards. The following quote supports this idea:

And also, not having enough gowns, like I... like that young guy, we,,. wanted to get him washed up. He wanted to move on, he wanted to do things and get out of bed and get... And there wasn't even a... We had called for bariatric gowns. And they said they would send them up. In two days, we never had ones that were big enough to fit him. So he would wear, he was wearing a sheet. (Nurse 11: lines 209-214)

A number of participants went on to say that even when bariatric gowns are ordered, they are usually not sent to the unit that day or even the next day. This particular example indicates that nurses may face unnecessary organizational barriers when trying to access the most basic resources for PLWO. Nurses not only encountered difficulties associated with limited accessibility and availability of physical resources but also lacked awareness of what physical resources are available, and where to find them on the unit or in the hospital. The following quote indicates that this lack of awareness was common among nurses working in the ICU:

And we have one oversized commode which nobody really knows where it is. (...) So once they're extubated and maybe getting up and moving around, depending on their previous activity level, it's hard to find. We have stuff as in... we may have stuff, but it's not common knowledge and it's not readily accessible, I think. (Nurse 3: lines 82-95)

The lack of accessibility, availability and awareness of physical resources was associated with an increased workload and increased risk or actual occurrences of physical injuries among ICU nurses. The following quote substantiates this argument:

Because we didn't have the right equipment and I... this gentleman was so large that I had to stand on a stool to do chest compressions. And we didn't have any proper stools for doing that. And the one that I was on tipped and I folded my wrist and strained my wrist while I was doing CPR because I slipped off the stool. So that hurt a lot. (Nurse 3: lines 74-77)

The analysis revealed that the experience of providing care to PLWO may be negatively or positively shaped by accessibility, availability and awareness of existing physical resources in the ICU. It also sheds light on the limits of existing physical resources and how these impact the experiences of nurses in the ICU. For instance, one participant noted, "We've got the bariatric lifts which you can't really use for a dressing" (Nurse 2: line 31). The following quote describes further what it is like to provide nursing care with the equipment present in the ICU:

... my... patient, the commode actually sat, the limit was lower than what his weight was. And so I asked our team leader if I should try it, because I didn't want him to have a disaster. She said, "Yes, try it." But I was kind of like, "Hail, Mary" like put him on the commode and hope it doesn't like break underneath him. (Nurse 11: lines 189-192)

During the interviews, nurses talked about the limits of physical resources and challenges associated with the use of the bariatric equipment in the ICU. This quote describes the physical difficulties nurses experience despite the availability and accessibility of bariatric lifts.

... yes, you have those, you can use a mechanical lift for turns to a certain degree. But there's no mechanical lift to help you lift an arm or a leg, or even lifting their shoulders and their heads to switch the pillow underneath. People's shoulders weigh a lot, but on a bariatric patient it weighs a lot more. And there's really no good body mechanics for lifting the shoulders of somebody. (Nurse 3: lines 255-260)

The following quote describes the challenges nurses experience when providing care to a PLWO in a bariatric bed:

Oh, okay, well, the certain brand of bed we have in the ICU is, it's probably a lot larger than it needs to be for any patient. So it's hard... it's hard just because of the size. So when I... My patient's hopefully in the middle of the bed. And for me reaching even from one side of the bed, to get to the centre of the patient, it's a far reach. I often grab a stool and I have to stand on a stool. Then, my balance is kind of off to reach the patient. (Nurse 7: lines 120-130)

Bariatric equipment was described as a key component of the experience of caring for PLWO in the ICU. On numerous occasions, participants voiced the importance of bariatric equipment (specifically ceiling lifts, bariatric beds, slider sheets) when providing care to PLWO. This equipment was deemed indispensable, and nurses made sure it was available at the beginning of their shifts before they had even entered the patient's room.

So I find I'll use the lift to turn them over, tuck the pillows under. And I'll lift them up and move the bed down instead of pulling them up in the bed.... But it... yes. And I will ask to have them moved into a room with a lift.

**Okay.**

That's probably all because I have hurt my back before.... And I'm not doing it again. (Nurse 2: lines 79-81)

When unable to access bariatric equipment, nurses will automatically report to their supervisor and request for this equipment to be made available. Working with lifts and bariatric beds was described by participants as a way to safely care for the PLWO while protecting themselves from physical injury, decreasing their physical workload and organizing their care. As previously noted, if bariatric equipment is not accessible to nurses, more persons are required to help them, and the nurses and PLWO may encounter nursing care delays.

Especially when it's busy, because you need more people to do more of the lifting and stuff. And if it's busy, then you have to wait. Or if, on nights, there's less people around too, sometimes I find it has to wait. (Nurse 9: lines 35-37)

Participants identified a number of *informational resources* that impacted their experiences of providing care to PLWO. These resources were deemed essential to ensure patient safety and to provide competent care in the ICU context. These resources included dietitians, social workers, spiritual care workers and pharmacists. The ICU dietitians assist nurses in determining what type of diet each PLWO requires to meet their caloric, nutrient and fat needs while in critical condition. The ICU social workers provide guidance with discharge planning, referral to community-based resources and psychosocial issues affecting both patients and their families. The spiritual care workers provide support to PLWO and their families in complex care situations that often give rise to tensions, blame, frustrations, and negative feelings related to obesity. Finally, ICU pharmacists assist nurses in determining safe and effective medications dosages, because existing protocols for intravenous medications are not adapted to PLWO and may create situations in which nurses have to administer dosages that fall outside existing ICU protocols. Nurses who work night shifts face significant barriers accessing these resources, because dietitians, social workers, spiritual care workers, and pharmacists only work eight-hour shifts during the day and are not available between 1700 and 0700.

When asked about their experiences of providing care to PLWO, participants insisted on the importance of *human resources*, namely, physiotherapists, occupational therapists, orderlies, and nurse colleagues. Physiotherapists assist nurses with the physical rehabilitation process by ambulating patients and providing specialized care, such as range of motion exercises and chest physiotherapy. They also ensure that weight specific assistive devices, such as bariatric walkers and canes, are available if needed. Occupational therapists ensure that patients have access to personalized bariatric equipment to ambulate and mobilize, including weight-specific wheelchairs. Nurses assist one another throughout a 12-hour shift, whether it is to cover during breaks, to help with turns, bathing, linen changes, skin assessments and procedures such as x-rays, dressing changes or bone marrow biopsies, for example. Nurses also provide one another with emotional support and times to voice feelings of frustration or questions. There are two orderlies (one orderly is assigned to each half of the patient rooms) available in the ICU each 12-hour shift; they are essential to completing patient-care tasks, whether patients are non-obese or PLWO. Orderlies provide physical assistance to turn, reposition, and bathe all patients. On any given day, there are 24 to 27 nurses in the ICU, with two orderlies to assist with care.

Again, some of these resources (e.g., physiotherapists and occupational therapists) are difficult to access outside regular office hours. In addition, occupational therapists are only available in the ICU one to two days a week to support nurses providing care to PLWO. Consequently, the nurses who care for the PLWO during the night (1900 to 0700) have even fewer resources to rely on for assistance in caring for PLWO, ultimately increasing their workload and responsibilities.

### 5.4.2 Working with Each Other

This study highlights the impact of resources (especially physical and human resources) on the way nurses work with each other in the ICU context. During the interviews, participants clearly explained that the relationship between nurses providing care to PLWO and their nurse colleagues is influenced by what is available and what is not available within the ICU environment.

You know what? Usually if that's the case I would take a look in a room and go, "Okay, do I have a mechanical lift in here?" Because if I have a mechanical lift in the room, it decreases the number of people that I need by at least half so I know that I could manage, I could manage with myself and an orderly at the very least with a mechanical lift. Frankly, I don't know why we don't think about that more often, but, I mean, not every room we have either is equipped with a mechanical lift. So I think usually, in my mind anyway, the first thing I think of is getting all the manpower available because, even when I was learning, like doing my, my nursing education, the hospitals that I worked at did not have the kind of technology that we have here. (Nurse 1: lines 436-444)

There was a general consensus that "it's difficult to find volunteers to come and help you, you know, when you need to provide basic care to those patients" (Nurse 5: lines 15-16). A number of the interviews revealed that, although the care of PLWO is not that different from that of other ICU patients, it requires more persons to assist with the most basic physical tasks, higher levels of teamwork throughout the 12-hour shift, and more coordination to get other nurse colleagues to help. For example, nurses described situations when, instead of requiring two persons for a turn, nurses required four to five persons to complete this task every two hours and also to provide physical care. Due to the increased numbers of nurses needed to complete basic tasks for these PLWO, these nurses must work together more often and for greater amounts of time. Consequently, this phenomenon impacts the way nurses work with each other. In turn, it creates situations where it is difficult to find other nurses to help, and situations where nurses have to rely heavily on colleagues to assist them.

... I think it works pretty much the same way with bariatric patients as it does with a non-bariatric patient. You just need more of it instead of having one or two people to help you, you need four to eight depending on the patient's weight. ... Trying to find that many people is difficult because everybody's busy. At least most people are busy. And people who are not busy and don't like to help usually make themselves scarce ...

**Okay.**

... when there's a bariatric patient around. So you got to kind of hope that you don't get buddied with that type of nurses. (Nurse 3: lines 388-395)

Two types of experiences were described by participants. The first experience was based on the feeling or perception that some of their nurse colleagues found ways to be busy with their own patient in order to avoid situations where they would be asked to provide extra help to complete physical tasks. The second experience was described by a few participants who noted that assistance from nurse colleagues depended on which staff were scheduled for a given shift. These two experiences were presented in these participants' responses:

But it depends, it depends... who's on.

**Okay. So...**

So, some people gel well as a team... and want to be helpful, and I think are empathic to the nurse with the morbidly obese patient, that they might be a little bit busier, they're going to need help with turns and they make themselves available. Then, you... That's scenario one. Then, you have scenario 2 where people are, "Oh, I hear there's a morbidly obese patient in room 27." They're going to try and stay busy and keep to themselves. So that they're not in helping. Now whether that's from... Why? Is it laziness, is it, "I just don't want to help that particular nurse who's in with that particular patient"? Why that is.... (Nurse 7: lines 942-975)

Well, I think, I think it depends on, you know, who's working with you, I find. There's some people that are like, "Oh well, you know, my, my elbow hurts so I can't help you with turns, so you're going to have to find other people." Or sometimes, I find, sometimes it's great, because there are people like, "Oh, if you need me to help with that turn, I'll be there." And, you know, everyone works together. (Nurse 11: lines 305-310)

While nurses acknowledged that their nurse colleagues may not be able to assist them because they are legitimately preoccupied with their own patients, or are unavailable because of the needs

of more critically ill patients on the unit, they also talked about avoidance, reluctance and unwillingness to help as common reactions faced by nurses who provided care to PLWO.

So having someone who's larger size being incontinent, to make sure you're cleaning them well, preventing any skin ulceration, also to get the, the people in to help you turn the patient and, change the bedding, that sort of thing, to make sure the patient has a clean bed. Just to gather enough people sometimes. And sometimes, your colleagues are like, "Oh, we have to change your bed again. I'm busy here." Or maybe they're not that busy, but not willing, really wanting to help again. (Nurse 7: lines 207-212)

A few participants noted that some colleagues did not seem to "care as much" about PLWO and expressed negative feelings toward this patient population, which, in turn, impacted their willingness to assist with physical care and provide help when needed.

I think there is a stigma out there about, you know, these patients being, smelling bad or,, just being, "Well, if they hadn't eaten so much, they wouldn't have gotten this way." And then as a result people just don't want to help, they just don't care as much as they do about a patient who maybe isn't that size. (Nurse 5: lines 27-30)

A number of participants also observed that there was a tendency to ask nurses whom they knew would help them, thus creating situations where the same nurses were being repeatedly asked and used to assist in patient care. This resulted in physical fatigue or injury, and inadvertently led to nurses refusing to provide assistance and avoiding situations where help was needed. The following quote affirms the above idea:

I think it, if you're on for two or three days and your buddies are on for two or three days, I think you end up, drawing on the, the greater unit more. Like any available nurse to your room kind of thing. Because I think everybody, everybody gets fatigued. (Nurse 2: lines 306-309)

A nurse's willingness to help their colleagues with the physical care of the PLWO is complicated and perhaps affected by one factor or a combination of the factors that have been discussed thus far. The analysis revealed that a nurse's previous experiences with physical injuries (often when providing care to a PLWO) could decrease the likelihood of a nurse assisting a colleague or being available to help. It was understood that nurses with past injuries were often concerned with the

risk of physical injury when helping with PLWO, and, ultimately, they could be actively protecting themselves by not helping others on the unit.

I mean, it definitely depends on the person you're asking to help you. It's like some people don't mind and some people really do mind or some people have injured themselves and maybe they don't want to put themselves at risk and... you know.  
(Nurse 6: lines 34-37)

A few of the ICU nurses interviewed denied ever having difficulties or problems getting assistance and help from nurse colleagues. Many nurses strived to provide PLWO with good nursing care and to work as a cohesive team. Nurses often worked with each other in an attempt to maintain the same level of care for PLWO, to fill the existing gaps in physical resources, and to compensate for the limitations of bariatric equipment at hand. As such, it was noted on multiple occasions that providing care to PLWO in the ICU required additional support from nursing colleagues.

The nurses who were interviewed had a variety of experiences caring for the PLWO in the ICU environment. These experiences were ultimately formed by the ICU's existing resources as well as by what these nurses felt needed to be improved or added to make this environment safer and more efficient. Finally, the influence of the unit's resources and needs on the nurse–nurse relationships is a complicated phenomenon that could be positively shaped if changes were made and needs were met.

### **5.4.3 Needs**

There were a wide variety of environmental needs put forth during the participant interviews (see Table 4). These needs were identified by participants and are supported by the research findings presented thus far. Recommendations that address these specific needs will be discussed in more detail in Chapter 6.

**Table 4.** Needs of ICU nurses

NEEDS	DETAILS
<b>INFORMATIONAL</b>	<ul style="list-style-type: none"> <li>• Skills in counselling PLWO on health and psychosocial issues</li> <li>• Sensitivity training to meet the mental, emotional and mental needs of patients and families</li> <li>• Education to discuss the emotional needs of PLWO</li> <li>• Feedback from a previous PLWO on their ICU experience               <ul style="list-style-type: none"> <li>• Experience during direct physical care</li> <li>• Needs that are not being addressed</li> <li>• Strategies that could improve the way care is provided</li> </ul> </li> <li>• In-service presentations by bariatric surgeons, weight management consultants, bariatric nurse educator / specialist</li> <li>• In-service on bariatric equipment (i.e., lifts and bariatric beds) to ensure all staff use the equipment correctly</li> <li>• In-service on skin care for this specific patient population and other specialized care required to improve outcomes</li> <li>• In-service on special considerations for routine tests and procedures like 12 lead ECG, chest x-ray, and so forth</li> <li>• In-service for ICU team on medication dosing for PLWO and pharmacological considerations</li> <li>• In-service for ICU nurses on nutritional aspects of providing care to PLWO in the ICU and nutritional recommendations</li> <li>• Education for ICU residents about the impact of orders on the planning of patient care and the nursing staff</li> <li>• Quick review session with physiotherapist on proper body mechanics and how to protect yourself when lifting a PLWO</li> <li>• Standardized information on discharge planning for PLWO</li> </ul>
<b>CLINICAL</b>	<ul style="list-style-type: none"> <li>• Standards of care that provide guidance to nurses who provide care to PLWO in the ICU</li> <li>• Standard turning schedule for PLWO</li> </ul>
<b>PRACTICAL</b>	<ul style="list-style-type: none"> <li>• More equipment (i.e., step stools, better bariatric beds that facilitate turning, a lift in each room, and so on)</li> <li>• Extra support workers (i.e., orderlies, nurses or a lift team to turn patients every 2 hours and assist with personal care)</li> <li>• TED stockings and SCD's in bariatric sizes</li> <li>• Firmer pillows that will keep the patient turned and not fall flat</li> <li>• More information available on what programs are available for PLWO after ICU (i.e., bariatric rehab centre, etc.)</li> </ul>

**ORGANIZATIONAL  
(UNIT OR  
HOSPITAL)**

- Support from management after work-related injuries
- Support from gastric bypass surgeons and the weight management clinic services to develop and implement standards of care for PLWO
- Access to expert clinical nurse specialist or advanced practice nurse who is specialized in bariatric care for consultation, education, debriefing, and so forth
- Assignment of the larger rooms to bariatric patients to ensure the safety of nurses and optimal movement within the space
- Access to nutritious, not processed meals during the ICU stay
- Review of patient assignment system and rotations
- Adjusting resources distribution to ensure that quality of care is maintained and that nurses are not at risk for physical injury

## CHAPTER 6

### DISCUSSION

The goal of this qualitative study was to examine the experiences of ICU nurses who work with PLWO and how these experiences affect the way they provide care. More specifically, this study was designed to describe and explore the inclusionary and exclusionary practices developed by nurses providing care to PLWO by drawing Canales' (2000) Othering framework. Lastly, an additional goal of this study was to document the needs of ICU nurses with respect to the care of PLWO and areas of improvement in the ICU.

A total of 11 ICU nurses were interviewed for this study. Data analysis followed the principles of Applied Thematic Analysis (ATA) and revealed four themes. The first theme describes how the PLWO become Other in the ICU context. The second theme focuses on exclusionary Othering and how it manifests itself in the way PLWO are differentiated, cared for, and viewed in the ICU context. The third theme sheds light on inclusionary Othering in the form of strategies that are used by ICU nurses to engage with PLWO in a way that is inclusive and transformative. Finally, the last theme concentrates on the ICU environment itself and the resources available (or not available) to nurses, with a particular emphasis on the needs of nurses who provide care to PLWO.

This chapter presents a discussion of the study findings presented in Chapter 5. These findings will be compared and contrasted with the relevant literature on the subject. The discussion will revolve around two themes that arose from the findings. The first theme will discuss two major drivers of exclusionary Othering, while the second theme will highlight the limits of inclusionary Othering (as described in the nursing literature thus far) in the ICU context. The final portion of this chapter will discuss the limitations of the study, and concludes with the resulting implications for education, practice, research, and theory in nursing.

## 6.1 Where Nurses Work and How They Feel About Their Work Matters

In this study, we found that PLWO were constructed and referred to as “different” from other “normal size” patients in the ICU. During the analysis, close attention was placed on language, word choices, expressions, and the way nurses described working with PLWO: as causing “extra physical strain,” as being “physically more demanding,” “work intensive” and “tiresome,” as requiring “a lot more physical effort,” and simply as being overall “harder” to work with than other patients in the ICU. The interviews revealed that “working with the Other” captured the idea that PLWO were not only physically “different” from other patients, but they also required “different” nursing care. While nurses spoke of trying to provide PLWO with the same care as any other patient in the ICU, they often were unable to do so (because of obstacles related to lack of resources to assist with physical care, ICU nursing care, and routine care such as turning and positioning), or they were unsure how to provide this care (due to lack of clinical guidelines, practice standards, resources, and so forth). Additionally, nurses experienced feelings of wanting to provide PLWO with the same level of care and, on the other hand, opposing feelings of repulsion, disgust, anger, frustration, blame, and fear, which were often produced and intensified by the work environment. These conflicting feelings often occurred simultaneously while nurses provided care for PLWO, and this phenomenon allowed for exclusionary Othering to manifest itself in different ways. During the analysis, it became clear that where nurses work and how they feel about their work were two important drivers of exclusionary Othering in the ICU – even more so than how nurses feel about PLWO and obesity more generally.

This study suggests that the ICU context functions as a driver of exclusionary Othering. Building on the work of Johnson and colleagues (2004) who conducted a study of South Asian immigrant women in Vancouver, it is important to recognize that exclusionary Othering *is*

contextual. Their ethnographic study revealed that organizational culture, work environment, and institutional practices contribute to Othering by excluding patients who do not easily fit into routines, the standardized clinical pathways, and the “normal” ways of providing care that are seen as essential components of a streamlined and efficient health care system. In this context, health care providers, including nurses, will often construct patients who are “different” or require “different” care as “*difficult to deal with and as burdens on an already resource strapped system*” (p.266, emphasis added). Johnson and colleagues (2004) also found that “emphasizing how health care institutions provide uniform and efficient services, have rigid appointment times and treatment schedules and limited time spent with patients compounded exclusionary experiences [within their research setting]” (p.266). This study had very similar contextual factors as well as similar findings to those noted by Johnson et al. (2004), including rigid treatment schedules and routine practices that need to be carried out in a specific way, where nurses reported opposing feelings of working with PLWO, and where PLWO were viewed as being “*difficult to deal with.*” Nurses’ feelings and views arose from the extra effort associated with caring for PLWO and operating within an environment developed for those who are “normal weight”, as well as the contextual factors noted above. In this sense, the ICU should be seen and understood as a space that makes Othering possible simply by being what it is: a space that is characterized by fixed routines or by unalterable schedules designed for a certain kind of patient, and that is organized in a way that is meant to be efficient.

The original framework developed by Canales (2000)—focused solely on exclusionary Othering as a phenomenon that takes place between two individuals (a nurse and a patient) and in a social interaction—does not account for the ways in which context shapes this interaction. While Canales argued that exclusionary Othering “operates at multiple levels, within individuals, families, communities, and society as a whole” (Canales, 2000, p.16), this particular dimension of the framework is underdeveloped and understudied in the current state of the nursing

literature. To date, nursing research guided by this framework has been largely focused on the interaction between the nurse and the patient. This narrow focus has translated into a better understanding of attitudes, perceptions, and behaviours, but has created an important gap in research on social, situational, organizational and institutional influences that perpetuate exclusionary Othering in health care. This critique is consistent with the work of Johnson and colleagues (2004) who argue that “it is important to recognize that individual interactions are embedded in a larger situational and social context” (Johnson et al., 2004, p.265). In this study of nurses’ experiences with PLWO, it was found that individual interactions between ICU nurses and PLWO were embedded in a context where it was “difficult” to provide the same care, to provide quality care, and sometimes, to provide care altogether. Factors such as the patient’s weight, anatomy, illness, condition, and acuity were identified as important factors in the interviews. However, other factors such as the ICU environment, the available resources, and the priorities of the ICU were also identified as contributing to making nurses (1) feel bad about the care they provided, (2) feel frustrated, scared, tired, resentful, isolated, and so on, and (3) feel differently about PLWO.

How nurses feel about their work is important to consider if we want to adopt a broader understanding of exclusionary Othering. In this study, nurses encountered many difficulties ranging from accessing equipment and basic supplies (e.g., gowns), finding additional support and resources to assist with care, accessing clinical information and guidelines, making sound clinical decisions that are evidence-informed, attending to all the care needs of the patient, stabilizing and monitoring the patient, intervening in an effective way in life-threatening situations, and providing safe nursing care. These difficulties were linked to feelings of inadequacy for not being able to provide optimal care to PLWO. They were also linked to nurses finding themselves in situations where they felt on “the edge of providing safe care.” The study findings suggest that the way nurses feel about the care they provide to PLWO is an additional

driver of exclusionary Othering. Although this is not reflected in the work of Johnson and colleagues (2004) or in the original framework of Canales (2000), it is consistent with the work of Jacob (2010) in the field of forensic psychiatry. In fact, Jacob (2010) found that the way nurses feel about the care they provide and the potential for recovery in long-term forensic psychiatric settings shapes the way they feel about their patients. In Jacob's study, nurses were much more likely to disconnect and disengage from patients when they perceived their care as meaningless or as having little impact on recovery. This phenomenon signals that exclusionary Othering is not only driven by the context of *where nurses work*, but it also driven by the way nurses *feel about their work*. Here, we see many similarities between the findings of this study where nurses' feeling on the edge of providing safe care to PLWO in the ICU during times of critical illness and Jacob's (2010) findings of nurses feeling on the verge of providing meaningless care to forensic psychiatric patients over the course of years and sometimes decades. In both cases, nurses are questioning the care provided to the groups within their specific settings due to nurses' experiences with Othering, both inclusionary and exclusionary. The patient population and the care setting are different, but the exclusionary process at play is very much the same – and the Othering framework would benefit from further development to provide more insight into the relationship between Othering, the patient population and patient care settings.

Overall, this study supports the need to look beyond the current understanding of exclusionary Othering in order to explore new empirical and theoretical understandings of this complex process. When this process is only studied in social interaction, there is a risk of ignoring powerful forces at play in the construction of the patient as Other. There is also a risk of misrepresenting exclusionary Othering as the unfortunate outcome of negative attitudes and perceptions, as something that can be easily fixed by sensitivity training, and as a process that takes place in the person rather than in context.

## 6.2 How Nurses Relate to Patients, Colleagues, and Context Matters

Canales' (2010) 10-year analysis and critique of how the Othering framework has been applied to the field of nursing found that there was limited application of inclusionary Othering and an extensive application of exclusionary Othering in the literature. This is consistent with the literature review we conducted in preparation for this study. Inclusionary Othering has been typically defined as the "positive" and transformative use of differentiation to connect with and relate to the patient as a person. As such, nurses who apply inclusionary Othering will recognize that the patient is "different" from themselves, but will attempt to connect by role taking, by reconceptualizing meanings and understandings of difference, and by seeing themselves as allies. In this study, ICU nurses used a number of inclusionary practices when working with PLWO. They used role taking when they tried to "put themselves in their patients' shoes" and to foster a human connection with the patient. This is consistent with the findings of Whitfield and Grassley (2008) and Sikorski and colleagues (2012), who found that fostering a human connection with the patient can result in a less negative view of that patient. Nurses also described how they "kept their distance" from instances of obesity bias during their shift and especially from colleagues' negatives comments during end of shift report. They also "kept their distance" from their own preconceived ideas about PLWO, and tried to leave their judgements at the door when entering the patient's room. In addition, nurses explained how they tried to "get to know the patient" as a person (as a "human being") and to overcome their own negative attitudes, feelings and perceptions of PLWO. These inclusionary practices were developed by participants to provide PLWO with the same care as the other patients in the ICU, but they were shown to have a number of limits. These limits need to be acknowledged and further explored in subsequent research projects because of their implications for inclusionary Othering and the Othering framework more generally.

The inability to engage with the patient through different forms of communication is an important limitation of inclusionary Othering in the ICU context. Since the majority of patients are intubated and sedated in the ICU, nurses found it difficult to build human connections with and relate to PLWO. They also found it challenging to role take not only because of the inability to communicate with their patients but also because of their inability to relate personally with the situation that they were in as persons living with obesity. In this regard, the study findings exposed two assumptions about inclusionary Othering: (1) inclusionary Othering relies on the ability to communicate with the patient; and (2) it requires a human connection that makes it possible for the nurse to imagine herself in a completely different personal situation — on a physical, psychological, emotional and social level. The assumptions have not been discussed in the literature to date. Yet, they played an important role in limiting the participants' ability to connect with and relate to PLWO. This raises questions about the applicability of the Othering framework in the ICU and other clinical areas where patients are unconscious and unresponsive. It also raises questions about the centrality of role taking in the overall framework. Is role taking experienced the same way by nurses, regardless of the patients they work with? In this study, nurses seemed to suggest that role taking was more challenging with PLWO than with other patients who face situations of social vulnerability and marginalization because of the physical dimension of that experience. The nature of the intensive care setting and the physical difference that separated them from their patient made it difficult for them to engage with PLWO in a way that was inclusive and transformative.

Three important barriers of inclusionary Othering were identified in this study. The personality traits, attitudes, and behaviours of PLWO were regrouped and identified as the first barrier. When nurses worked with patients who were described as being nice, polite, patient, responsible, responsive to their health crisis situation, accountable, and willing to change, they seemed much more inclined to provide care in an inclusionary manner. However, they

explained that it was “harder” to connect and engage with PLWO when these conditions were not met. This suggests that other processes, such as the construction of the patient as “good” or “bad,” are at play here. The second barrier was identified when comparing interview excerpts of nurses who were successful at drawing from past positive experiences and personal experiences to connect to PLWO in a different way with interviews of those who were not. This comparison suggests that not having a personal connection with someone who is living with obesity and not having any positive past experiences to draw from can limit the ability to provide care in an inclusionary manner. This particular dimension of inclusionary Othering is not discussed in the nursing literature. The third and final barrier is more theoretical than empirical. It was determined early on in the course of this study that context and group dynamics had the potential to facilitate (or preclude) inclusionary Othering. Yet, theoretically, inclusionary Othering has always been analyzed, researched, and discussed as a process that only takes place between the nurse and the patient. In fact, Canales’ (2000) framework does not take into account the effect of context or the group dynamics present in any given care situation. As a result, it tends to overlook macro level influences that shape nursing practice.

As was discussed in Chapter 3, there has been a limited use of Othering to study the experience of nurses who provide care to PLWO: only two articles could be located during the literature review process (Aranda & McGreevy, 2012; Thompson & Kumar, 2011). These two articles did not draw attention to inclusionary Othering when they discussed their findings, nor did they report on the ways in which nurses tried to connect with PLWO. This is consistent with Canales’ (2010) own critique of the current state of the nursing literature on the Othering framework and the absence of inclusionary dimensions of this framework in published research. This study presents an opportunity for further development of this dimension and the possibility for new applications of the framework to the ICU context more specifically. While the inclusionary practices reported in Chapter 5 require further exploration, they offer new directions

to think about inclusionary Othering. Additionally, the barriers identified in the previous section raise interesting questions about the current limitations of inclusionary Othering and assumptions about who the patient is, what the patient is like, what type of care is offered, and what strategies can / cannot be used by nurses in their practice settings. The original framework published by Canales in 2000 did not take into consideration that factors such as context and resources impact how nurses relate to their patients. It also did not take into account that the care environment and workload impact how nurses relate to colleagues. And finally, it did not consider that nurses move fluidly between positive and negative attitudes, feelings and perceptions, that their practices fluctuate depending on interaction with colleagues, care situations and context, and that personal characteristics of both the patient and the nurse can act as facilitators or barriers of inclusionary Othering. The following portion of this chapter will present the limitations of the study and the implications of the study findings — including the implications for theory development.

### **6.3 Limitations of the Study**

While this study had a number of strengths (see Table 5), it also had some limitations. For example, it would have benefited from the inclusion of ICU nurses with a range of professional trajectories in the ICU and with longer experience in nursing generally. Only two of the research participants had greater than 15 years of experience as registered nurses, and this might have influenced the ways participants viewed, talked about, and cared for PLWO. Secondly, the study might have benefited further from a larger sample size, which might have resulted in other themes and insightful information on the experience of ICU nurses. Thirdly, the study was limited in the number of male participants, despite the fact that their experiences with PLWO differs from female nurses. During the interviews, male participants from the study felt that they were frequently asked to assist with turns, positioning, personal care and other physical patient

care tasks by female colleagues. Participants felt that this occurred more often than female nurses asking other female nurses to help. A female participant supported this observation when she stated that she frequently asked men to assist her more often because of their physical size and perceived strength. Although, this finding was not discussed in Chapter 5, the presence of these feelings indicates that male nurses could have different experiences when a PLWO is an ICU patient, and these experiences and feelings should be explored further. Fourthly, the participants of the study, on majority, were fairly young, and more participants above the age of 40 might have provided different ways of understanding the experience of providing care to PLWO and coping with the challenges that this experience entails. Finally, none of the nurses who participated in the study had a BMI above “normal,” and, consequently, this may have provided a limited understanding of the research phenomenon. ICU nurses who have a higher BMI might provide another layer of complexity to the experience of working with PLWO in this particular setting.

**Table 5.** Key strengths of the study

- |   |
|---|
| <ul style="list-style-type: none"> <li>• Explorative and descriptive design</li> <li>• In-depth description of the context</li> <li>• Nursing theoretical framework</li> <li>• Theoretical framework on Othering <ul style="list-style-type: none"> <li>○ Exclusionary Othering</li> <li>○ Inclusionary Othering</li> </ul> </li> <li>• Contextual approach to Othering</li> <li>• Identification of resources and needs</li> </ul> |
|---|

## 6.4 Implications of the Research Findings

### 6.4.1 Implications for Education

At the undergraduate level, the framework developed by Canales (2000) could inform the content of specific nursing courses (e.g., professionalism and ethics courses) to ensure that

nursing students learn to recognize the process of Othering and the drivers of Othering in clinical practice, in addition to specific inclusionary strategies that can be used when working with patients who are seen as Others. This framework would meet an educational need and also provide nursing students with the tools to think about and assess how power can be used in ways that are exclusionary or inclusionary. Nursing students would also benefit from the inclusion of bariatric sensitivity training and nursing content that is tailored to the care needs of PLWO. At an organizational level, continuing education for registered nurses who work in the ICU should include bariatric sensitivity training as well as in-service presentations that meet the clinical, practical, and informational needs of nurses identified in Chapter 5. While a workshop informed by the framework of Canales (2000) could also be beneficial to ICU nurses, it would need to be accompanied by important changes to the care environment (resource availability and allocation, support, equipment, workload management, etc.) in order to have a “real” impact on the care provided to PLWO. As suggested by this study, education is not the only answer, but it is part of the solution.

#### **6.4.2 Implications for Nursing Practice**

Nurses working in the ICU would benefit from the development of strategies to prevent them from becoming emotionally, mentally and physically fatigued as a result of providing care to PLWO. Whether this is achieved through a lift team being made available to assist with physical care (including bathing, turning, positioning and dressing changes) or the development of patient care guidelines to assist nurses who provide care to PLWO in complex and acute situations, every possible solution to support ICU nurses should be carefully considered at the organizational level. These solutions should include changes in policies and procedures, including unit procedures. As suggested by this study, failing to see the need for and develop innovative solutions to support ICU nurses who provide care to PLWO could have a detrimental

impact on the quality of the care provided, the clinical outcomes, the experience of patients, and on the nurses themselves. These solutions may also reduce exclusionary Othering processes at play in the ICU and may support the implementation of inclusionary practices that are consistent with nursing values, professional obligations, ethical responsibilities, and standards of practice.

Debriefing is one innovative strategy that could be implemented to provide ICU nurses with the opportunity to talk about a negative experience, verbalize their concerns, express their needs, and find support. Debriefing could also assist nurses in overcoming their negative experiences; these experiences were revealed to have long-lasting effects and seemed to be the easiest to recall when participants were asked about their experience of providing care to PLWO. In fact, positive experiences seemed to have little or no impact on ICU nurses, and did not significantly impact the way nurses talked about what it means to provide care to PLWO. Understanding that one negative experience with a PLWO can alter the way nurses approach, feel about, perceive and care for other PLWO in the ICU affirms the importance of finding solutions that can alter this “chain reaction.”

Finally, ensuring that sufficient equipment is available and accessible should be a priority in the ICU context. A list of equipment available to all staff, along with the necessary details (e.g., description of the equipment, purpose, instructions, location, etc.), should be easy to find on the unit. This may be seen as a minor change, but it would save time, reduce the sense of frustration that many participants described in this study, improve patient care, decrease the risk of injuries, and improve the experience of providing care to PLWO more generally.

### **6.4.3 Implications for Research**

In light of the study findings, further research should focus on the experience of PLWO in the ICU. It should also include the perspective of family members who are often very present in the ICU and act as the point of contact between the patient and nurse — especially when the

patient is intubated, sedated or unable to respond to social interaction. The experiences of other team members in the ICU (e.g., pharmacists, dieticians, staff physicians, residents, medical students, social workers, physiotherapists, managers, team leaders and spiritual care providers) would also be extremely valuable, because the ICU is based on an inter-professional model of care. All of these professionals would be in a position to provide information that can deepen our understanding of the overall “care experience” in the ICU. Finally, comparative studies between hospitals and ICU units could help explore the impact of space, education, support, and resources on the experience of providing care to PLWO. It would also allow researchers to examine how organizational factors play a role in shaping that experience.

#### **6.4.4 Implications for Nursing Theory**

As suggested by this study, Othering is a fluid process. In other words, ICU nurses can feel and act in an exclusionary manner, and then feel and act in an inclusionary manner. When this process is separated into two distinct dimensions (exclusionary or inclusionary), there is a risk of constructing nurses as “good” or “bad”, rather than focusing on the complexity of exclusionary Othering and the limits of inclusionary Othering. There is also a risk of decontextualizing Othering to a point where the focus is placed solely on the nurse — how that nurse acts, thinks, and provides care to PLWO. In this study, the social context, the ICU environment, the organization of nursing care, and the nature of the care provided in the ICU were major drivers of exclusionary Othering. Limitations of inclusionary Othering were also highlighted and theoretical assumptions were questioned (e.g., patient is awake and talking, nurse is able to relate, time is available to connect, etc.). In addition, Othering appears to be a group process as much as it is an individual process. Thinking about fluidity, context, and group dynamics could provide new directions for the framework developed by Canales (2000). Furthermore, it could help researchers who study Othering in nursing to examine new ways of understanding

exclusionary and inclusionary practices. The study findings also suggest there is a need for further development of the framework to look more critically at organizational influences that contribute to or limit these practices (e.g., structural Othering).

## CONCLUSION

In closing, this research study has answered the main research question: *What are the experiences of ICU nurses working with the PLWO?* Through the research process, the study objectives were achieved. This research study described the experiences of nurses who worked with PLWO in the ICU, explored how nurses' experiences affected the way they cared for the PLWO, explored the practices and strategies ICU nurses used to care for this population, and, finally, identified the needs of ICU nurses caring for this population and the potential areas of improvement in the ICU. The study findings revealed that the experience of nurses who provide care to PLWO in the ICU environment is much more complicated than nurses simply having negative attitudes, perceptions and feelings towards this patient population. Therefore, if nurse researchers focus predominantly on these negative attitudes, perceptions, feelings and individual behaviours, they only observe a small aspect of the larger picture and, by extension, a small portion of the problem. As this study has shown, there are social, situational, organizational and institutional influences that have not been acknowledged to date in the literature, despite the fact that they contribute to exclusionary Othering; these unacknowledged factors influence nurses themselves and the way they provide care to PLWO as a result. Exploring these influences in a subsequent study could provide insight into how this phenomenon takes place in the ICU, and might raise important questions on the role of macro-level influences in shaping nurse–patient interactions.

## REFERENCES

[REDACTED] (2010). Information was retrieved on March 8, 2013 from:

[REDACTED]

Amy, N. K., Aalborg, A., Keranen, L., & Lyons, P. (2006). Barriers to routine gynecological cancer screening for White and African American obese women. *International Journal of Obesity, 30*(1), 147-155.

Aphramor, L., & Gingras, J. (2009). That remains to be seen: Disappeared feminist discourses on fat in dietetic theory and practice. In E. Rothblum & S. Solovay (Eds.), *The fat studies reader* (pp. 97-105). New York: New York University Press.

Aramburu, C., Drury, A., & Louis, M. (2002). Exploring the association between body weight, stigma of obesity, and health care avoidance. *Journal of the American Academy of Nurse Practitioners, 14*(12), 554-561.

Aranda, K., & McGreevy, D. (2012). Embodied empathy-in-action: overweight nurses' experiences of their interactions with overweight patients. *Nursing Inquiry, 1*-9.

Arzouman, J., Lacovara, J. E., Blackett, A., McDonald, P. K., Traver, G. & Bartholomeaux, F. (2006). Developing a comprehensive bariatric protocol: a template for improving patient care. *Medsurg Nursing, 15*(1), 21-26.

Astrup, A., Hill, J., & Rossner, S. (2004). The cause of obesity: Are we barking up the wrong tree? *Obesity Reviews, 5*(3), 125-127.

Bagley, C. R., Conklin, D. N., Isherwood, R. T., Pechiulis, D. R., & Watson, L. A. (1989). Attitudes of nurses toward obesity and obese patients. *Perceptual and Motor skills, 68*, 954.

- Beausoleil, N. (2009). An impossible task? Preventing disordered eating in the context of the current obesity panic. In J. Wright & V. Harwood (Eds.), *Biopolitics and the "obesity epidemic": Governing bodies* (pp. 93-107). New York: Routledge.
- Bleich, S. N., & Blendon, R. J. (2010). Public opinion and obesity. In R. J. Blendon, M. Brodie, J. M. Benson & D. E. Altman (Eds.), *American public opinion and health care* (pp. 359-378). Washington: CQ Press.
- Blumer, H. (1969). *Symbolic Interactionism: Perspectives and Method*. New Jersey: Prentice-Hall, Inc.
- Bochicchio, G.V., Joshi, M., Bochicchio, K., Nehman, S., Tracy, J. K., & Scalea, T. M. (2006). Impact of obesity in the critically ill trauma patient: A prospective study. *Journal of American College of Surgery*, 203, 533-538.
- Boero, N. (2007). All the news that's fat to print: The American 'obesity epidemic' and the media. *Qualitative Sociology*, 30, 41-60.
- Boero, N. (2009). Fat kid, working moms and the "epidemic of obesity": Race, class and mother blame. In E. Rothblum & S. Solovay, S. (Eds.), *The fat studies reader* (pp. 113-119). New York: New York University Press.
- Bovbjerg, V. E. (2008). The epidemiology of obesity: Causal roots-routes of cause. In E. M. Blass (Ed.), *Obesity: Causes, mechanisms, prevention and treatment* (pp. 19-72). Sunderland: Sinauer Associates, Inc.
- Brown, I. (2006). Nurses' attitudes towards adult patients who are obese: Literature review. *Journal of Advanced Nursing*, 2, 221-232.

- Brown, I., Stride, C., Psarou, A., Brewins, L., & Thompson, J. (2007). Management of obesity in primary care nurses' practices, beliefs and attitudes. *Journal of Advanced Nursing*, 59(4), 329-341.
- Brown, I., & Thompson, J. (2007). Primary care nurses' attitudes, beliefs and own body size in relation to obesity management. *Journal of Advanced Nursing*, 60(5), 535-543.
- Browne, A. J. (2007). Clinical encounters between nurses and first nations women in a Western Canadian Hospital. *Social Science & Medicine*, 64(10), 2165-2176.
- Brownell, K. D., & Hogan, K. B. (2003). *Food fight: The inside story of the food industry, America's obesity crisis, and what we can do about it*. New York: McGraw-Hill.
- Brownell, K., & Puhl, R. (2003). The weight management and obesity symposium: Stigma and discrimination in weight management and obesity. *The Permanente Journal*, 7(3), 21-23.
- Caelli, K., Ray, L., & Mill, J. (2003). 'Clear as mud': Toward greater clarity in generic qualitative research. *International Journal of Qualitative Methods*, 2(2), 1-13.
- Campesino, M. (2006). Beyond transculturalism: Critiques of cultural education in nursing. *Journal of Nursing Education*, 47(7), 298-304.
- Campos, P. (2004). *The obesity myth: Why America's obsession with weight is hazardous to your health*. New York: Penguin Books.
- Campos, P., Saguy, A., Ernsberger, P., Oliver, E., & Gaesser, G. (2006). The epidemiology of overweight and obesity: Public health crisis or moral panic? *International Journal of Epidemiology*, 35(1), 55-60.
- Canales, M. K. (2000). Othering: toward an understanding of difference. *Advances in Nursing Science*, 22(4), 16-31.

- Canales, M. K. (2004). Connecting to nativeness: The influence of women's American Indian identity on their health-care decisions. *Canadian Journal of Nursing Research, 36*(4), 18-44.
- Canales, M. K. (2010). Othering: Difference understood?? A 10-year analysis and critique of the nursing literature. *Advances in Nursing Science, 33*(1), 15-34.
- Canales, M. K., & Bowers, B. J. (2001). Expanding conceptualizations of culturally competent care. *Journal of Advanced Nursing, 36*(1), 102-111.
- Carpenter, K. M., Hasin, D. S., Allison, D. B., & Faith, M. S. (2000). Relationships between obesity and DSM-IV major depressive disorder, suicide ideation, and suicide attempts: Results from a general population study. *American Journal of Public Health, 90*, 252-257.
- Catalano, P. (2003). Editorial: Obesity and pregnancy-The propagation of a vicious cycle? *The Journal of Clinical Endocrinology and Metabolism, 88*(8), 3505-3506.
- Chambers, R., & Wakley, G. (2002). *Obesity and overweight matters in primary care*. Oxford: Radcliffe Medical Press.
- Chan, K-Y. (2009). "Othering" tactics and treatments of patients with HIV/AIDS: A study of the construct of professional ethics by Thai nurses and nursing trainees. *Critical Public Health, 19*(2), 181-191.
- Charlebois, D., & Wilmoth, D. (2004). Critical care of patients with obesity. *Critical Care Nurse, 24*(4), 19-27.
- Cohen, L., Perales, D., & Steadman, C. (2005). The O word: Why the focus on obesity is harmful to community health. *Californian Journal of Health Promotion, 3*(3), 154-161.

- Coulter, L. (1996). The deviance of obesity: The fat lady sings. In P. M. Lester (Ed.). *Images that injure: Pictorial stereotypes in the media* (pp.135-139). Westport: Praeger Publishers.
- Cramer, P., & Stewart, T. (1998). Thin is good, fat is bad: How early does it begin? *Journal of Applied Developmental Psychology, 19*, 429-451.
- Creswell, J. (2013). *Qualitative inquiry & research design: Choosing among five approaches* (3<sup>rd</sup> ed.). Thousand Oaks: Sage.
- Culbertson, M. J., & Smolen, D. M. (1999). Attitudes of RN students toward obese adult patients. *Journal of Nursing Education, 38*(2), 84-87.
- Davidson, J., & Callery, C. (2001). Care of the obesity surgery patient requiring immediate level care or intensive care. *Obesity Surgery, 11*, 93-97.
- Drake, D., Dutton, K., Engelke, M., McAuliffe, M., & Rose, M. A. (2005). Challenges that nurses face in caring for morbidly obese patients in the acute care setting. *Surgery for Obesity and Related Diseases, 1*, 462-466.
- Drevdahl, D. J., Canales, M. K., & Dorcy, K. S. (2008). Of goldfish tanks and moonlight tricks: Can cultural competency ameliorate health disparities. *Advances in Nursing Science, 31*(1), 13-27.
- Drevdahl, D. J., & Dorcy, K. (2007). Exclusive inclusion: The violation of human rights and US immigration policy. *Advances in Nursing Science, 30*(3), 290-302. .
- Eisenberg, M. E., Neumark- Sztainer, D., & Story, M. (2003). Associations of weight based teasing and emotional well-being among adolescents. *Archives of Pediatrics and Adolescent Medicine, 157*, 733-738.

- El-Solh, A., Sikka, P., Bozkanat, E., Jaafar, W., & Davies, J. (2001). Morbid obesity in the medical ICU. *Chest, 120*, 1989-1997.
- Ernsberger, P. (2009). Does social class explain the connection between weight and health? In E. Rothblum & S. Solovay (Eds.), *The fat studies reader* (pp. 25-36). New York: New York University Press.
- Falker, A. J., & Sledge, J. A. (2011). Utilizing a bariatric sensitivity educational module to decrease bariatric stigmatization by health care professionals. *Bariatric Nursing and Surgical Patient Care, 6*(2), 73-78.
- Gaesser, G. A. (2003). Weight, weight loss, and health: A closer look at the evidence. *Health Weight Journal, 17*, 8-11.
- Gaesser, G. A. (2006). Study "confirms" you can't be fat and healthy- But what do the data show? *Health at Every Size, 20*(1), 47-53.
- Gard, M. (2011). *The end of the obesity epidemic*. London: Routledge.
- Gard, M., & Wright, J. (2005). *The obesity epidemic: Science, morality and ideology*. London: Routledge.
- Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. New Jersey: Prentice-Hall, Inc.
- Gollust, S. E., Eboh, I., & Barry, C. L. (2012). Picturing obesity: Analyzing the social epidemiology of obesity conveyed through US news media images. *Social Science & Medicine, 74*, 1544-1551.

- Gray, D. P., & Thomas, D. (2005). Chapter 15: Critical analysis of “culture” in nursing literature: Implications for nursing education in the United States. *Annual Review of Nursing Education, 3*, 249-270.
- Greenberg, B. S., Eastin, M., Horshire, L., Lachlan, K., & Brownell, K. D. (2003). The portrayal of overweight and obese persons in commercial television. *American Journal of Public Health, 93*, 1342-1348.
- Grindel, M. E., & Grindel, C. G. (2006). Nursing care of the person having bariatric surgery. *Medsurg Nursing, 15*(3), 129-145.
- Grove, N. J., & Zwi, A. B. (2006). Our health and theirs: Forced migration, othering, and public health. *Social Science and Medicine, 62*, 1931-1942.
- Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research*. Thousand Oaks: Sage.
- Guba, E. G., & Lincoln, Y. S. (2005). Paradigmatic controversies, contradictions, and emerging confluences. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (3<sup>rd</sup> ed). (pp. 191-215). Thousand Oaks: Sage.
- Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods, 18*(1), 59-82.
- Guest, G., MacQueen, K. M., & Namey, E. E. (2012). *Applied thematic analysis*. Thousand Oaks: Sage.
- Gurjral, H., Tea, C., & Sheridan, M. (2011). Evaluation of nurse’s attitudes toward adult patients of size. *Surgery for Obesity and Related Diseases, 7*, 536-540.

- Hahler, B. (2002). Morbid obesity: A nursing care challenge. *Medsurg Nursing: Official Journal of the Academy of Medical-Surgical Nurses*, 11(2), 85-90.
- Halcomb, E. J., & Davidson, P. M. (2006). Is verbatim transcription of interview data always necessary? *Applied Nursing Research*, 19, 38-42.
- Hamilton, B., & Manias, E. (2006). 'She's manipulative and he's right off': a critical analysis of psychiatric nurses' oral and written language in the acute patient setting. *International Journal of Mental Health Nursing*, 15, 84-92.
- Health Canada (2006). *Obesity*. Retrieved on January 4, 2013 from: <http://www.hc-sc.gc.ca/hl-vs/iyh-vsv/life-vie/obes-eng.php>
- Herrick, C. (2007). *Risky bodies: Public health, social marketing and the governance of obesity*. *Geoforum*, 38(1), 90-102.
- Heuer, C. A., McClure, K. J., & Puhl, R. M. (2011). Obesity stigma in online news: A visual content analysis. *Journal of Health Communication: International Perspectives*, 16(9), 976-987.
- Hill, A. J. (2008). Social and psychological factors in obesity. In G. Williams & G. Fruhbeck (Eds.), *Obesity: Science to practice* (pp. 346-363). West Sussex: Wiley-Blackwell.
- Hill, J. O., & Peters, J. C. (1998). Environmental contributions to the obesity epidemic. *Science*, 280, 1371-1374.
- Himes, S., & Thompson, J. (2007). Fat stigmatization in television shows and movies: A content analysis. *Obesity*, 15, 712-715.
- Hofmann, B. (2010). Stuck in the middle: The many moral challenges with bariatric surgery. *The American Journal of Bioethics*, 10(12), 3-11.

- Holmes, B. J. (2009). Media coverage of Canada's obesity epidemic: Illustrating the subtleties of surveillance medicine. *Critical Public Health, 19*(2), 223-233.
- Holmes, D. (2003). Constructing monsters: Correctional discourses and nursing practice. *International Journal of Psychiatric Nursing Research, 8*, 942-962.
- Holmes, D., Perron, A., & O'Byrne, P. (2006). Understanding disgust in nursing: Abjection, self and the other. *Research and Theory for Nursing Practice: An International Journal, 20*(4), 305-315.
- Hoppe, R., & Ogden, J. (1997). Practice nurses' beliefs about obesity and weight related interventions in primary care. *International Journal of Obesity and Related Metabolic Disorders, 12*, 141-146.
- Ip, E. H., Marshall, S., Vitolins, M., Crandall, S. J., Davis, S., Miller, D., Kronner, D., Vaden, K., & Spangler, J. (2013). Measuring medical student attitudes and beliefs regarding patients who are obese. *Academic Medicine, 88*(2), 282-289.
- Jackson, D., Hutchinson, M., Everett, B., Mannix, J., Peters, K., Weaver, R., & Salamonson, Y. (2011). Struggling for legitimacy: Nursing students stories of organisational aggression, resilience and resistance. *Nursing Inquiry, 18*(2), 102-110.
- Jacob, J.D. (2010). *Fear and power in forensic psychiatry: Nurse-patient interactions in a secure environment* (Doctoral dissertation). University of Ottawa, Canada.
- Jacob, J. D., Gagnon, M., & Holmes, D. (2009). Nursing so-called monsters: On the importance of abjection and fear in forensic psychiatric nursing. *Journal of Forensic Nursing, 5*, 153-161.

- Jallinoja, P., Absetz, P., Kuronen, R., Nissinen, A., Talja, M., Uutela, A., & Patja, K. (2007). The dilemma of patient responsibility for lifestyle change: Perceptions among primary care physicians and nurses. *Scandinavian Journal of Primary Health Care, 25*, 244-249.
- James, W. P. T., & Gill, T. P. (2010). Prevention of Obesity. In G. A. Bray & C. Bouchard (Eds.), *Handbook of obesity: Clinical applications* (3<sup>rd</sup> ed.) (pp. 157-175). New York: Informa Healthcare USA, Inc.
- Jeffrey, C. A., & Kitto, S. (2006). Struggling to care: Nurses perceptions of caring for obese patients in an Australian bariatric ward. *Health Sociology Review, 15*(1), 71-82.
- Johnson, J. L., Bottoroff, J. L., Browne, A. J., Grewal, S., Hilton, B. A., & Clarke, H. (2004). Othering and being othered in the context of health care services. *Health Communication, 16*(2), 253-271.
- Jones, E., Farina, E.A., Hastorf, A. H., Markus, H., Miller, D. T., & Scott, R. A. (1984). *Social stigma: The psychology of marked relationships*. New York: W. H. Freeman and Company.
- Katzmarzyk, P. T. (2002). The Canadian obesity epidemic, 1985-1998. *Canadian Medical Association Journal, 166*, 1039-1040.
- Kim, S-H., & Willis, L. A. (2007). Talking about obesity: News framing of who is responsible for causing and fixing the problem. *Journal of Health Communication, 12*, 359-376.
- Kiraly, L., Hurt, R. T., & Van Way III, C.W. (2011). The outcomes of obese patients in critical care. *Journal of Parenteral and Enteral Nutrition, 35*(1), 29S-35S.

- Kirkey, S. (2011). Caring for obese patients poses daunting challenges: Intensive care units are reporting a rise in the number of patients with extreme body weight. *Montreal Gazette*. Retrieved from: [http://www.montrealgazette.com/story\\_print.html?id=4318741&sponsor](http://www.montrealgazette.com/story_print.html?id=4318741&sponsor)
- Kivimaki, M., Batty, G. D., Singh-Manoux, A., Nabi, H., Sabia, S., Tabak, A. G., Akbaralay, T. N., Vahtera, J., Marmot, M. G., & Jokela, M. (2009). Association between common mental disorder and obesity over the adult life course. *The British Journal of Psychiatry*, *195*(2), 149-155.
- Kuhnlein, H. V., Receveur, O., Soneida, R., & Egeland, G. M. (2004). Arctic indigenous peoples experience nutrition transition with changing dietary patterns and obesity. *The Journal of Nutrition*, *134*(6), 1447-1453.
- Lang, T., & Rayner, G. (2007). Overcoming policy cacophony on obesity: An ecological public health framework for policymakers. *Obesity Reviews*, *8*(s1), 165-181.
- Lawrence, R. G. (2004). Framing obesity: The evolution of news discourse on a public health issue. *Harvard International Journal of Press and Politics*, *9*, 56-75.
- Latner, J. D., & Stunkard, A. J. (2003). Getting worse: The stigmatization of obese children. *Obesity Research*, *11*, 452-456.
- Lenz, M., Richter, T., & Muhlhauser, I. (2009). The morbidity and mortality associated with overweight and obesity in adulthood: A systematic review. *Deutsches Arzteblatt International*, *106*(40), 641-648.
- Lieberman, D. L., Tybur, J. M., & Latner, J. D. (2011). Disgust sensitivity, obesity stigma and gender: Contamination psychology predicts weight bias for women, not men. *Obesity*, *20*(9), 1803-1814.

- Link, B. G., & Phelan, J. (2001). Conceptualizing stigma. *Annual Review of Sociology*, 27, 363-385.
- Luo, W., Morrison, H., de Groh, M., Waters, C., DesMeules, M., Jones-McLean, E., Ugnat, A.M., Desjardins, S., Lim, M., & Mao, Y. (2007). The burden of adult obesity in Canada. *Chronic Diseases in Canada*, 27(4), 135-144.
- Lupton, D. (1996). *Food, the body and the self*. London: Sage.
- Lupton, D. (2013). *Shortcuts: Fat*. New York: Routledge.
- Lyons, P. (2009). Prescription for harm: Diet industry influence, public health policy and the "obesity epidemic". In E. Rothblum & S. Solovay (Eds.), *The fat studies reader* (pp. 75-87). New York: New York University Press.
- MacCallum, E. (2002). Othering and psychiatric nursing. *Journal of Psychiatric and Mental Health Nursing*, 9, 87-94.
- Magnusdottir, H. (2005). Overcoming strangeness and communication barriers. *International Nursing Review*, 52, 263-269.
- Mark, D. (2005). Deaths attributable to obesity. *Journal of American Medical Association*, 293(15), 1918-1919.
- Martino, J. L., Stapleton, R. D., Wang, M., Day, A. G., Cahill, N. E., Dixon, A. E., Suratt, B. T., & Heyland, D. K. (2011). Extreme obesity and outcomes in critically ill patients. *Chest*, 140(5), 1198-1206.
- McClure, K. J., Puhl, R. M., & Heuer, C. A. (2011). Obesity in the news: Do photographic images of obese persons influence anti-fat attitudes? *Journal of Health Communication*, 16, 359-371.

- McGrath, M. (2008). The challenges of caring in a technological environment: Critical care nurses' experiences. *Journal of Clinical Nursing, 17*, 1096-1104.
- Meers, M. R., Koball, A. F., Oehlhof, M. W., Laurene, K. R., & Mushur-Eizenman, D. R. (2011). Assessing anti-fat bias in preschoolers: A comparison of a computer generated line-drawn figure array and photographic figure array. *Body Image, 8*, 293-296.
- Mill, J. E., Allen, M. N., & Morrow, R. A. (2001). Critical theory: Critical methodology to disciplinary foundations in nursing. *Canadian Journal of Nursing Research, 33*(2), 109-127.
- Mkandawire-Valhmu, L., Kako, P. M., & Stevens, P. E. (2010). Mentoring women faculty of color in nursing academia: Creating an environment that supports scholarly growth and retention. *Nursing Outlook, 58*(3), 135-141.
- Morse, J. M. (1994). "Emerging from the data": The cognitive processes of analysis in qualitative inquiry. *Critical issues in qualitative research methods* (pp. 23-43). Thousand Oaks: Sage, 23-43.
- Murphy Paul, A. (2008, July 13). Too fat and pregnant. *The New York Times*, Sect. MM, 19.
- Mushur-Eizenman, D. R., Holub, S.C., Hauser, J. C., & Young, K. M. (2007). The relationship between parents' anti-fat attitudes and restrictive feeding. *Obesity, 15*(8), 2095-2102.
- National Center for Health Statistics. (2008). Health, United States, 2008 with chart book. Available at: <http://www.cdc.gov/nchs/data/hus/hus08.pdf>
- Novak, N. L., & Brownell, K. D. (2011). Obesity: A public health approach. *The Psychiatric Clinics North of America, 34*, 895-909.

- Ogden, J., & Hoppe, R. (1998). Changing practice nurses' management of obesity. *Journal of Human Nutrition and Dietetics*, 11, 249-256.
- Ogle, K. R., & Glass, N. (2006). Mobile subjectivities: Positioning the nonunitary self in critical feminist and postmodern research. *Advances in Nursing Science*, 29(2), 170-180.
- Oliver, J. E. (2005). *Fat politics: The real story behind America's obesity epidemic*. Oxford: Oxford University Press.
- Oliver, J. E. (2006). The politics of pathology: How obesity became an epidemic disease. *Perspectives in Biology and Medicine*, 49(4), 611-627.
- Omeri, A., & Atkins, K. (2002). Lived experiences of immigrant nurses in New South Wales, Australia: Searching for meaning. *International Journal of Nursing Studies*, 39, 495-505.
- Pearl, R. L., Puhl, R. M., & Brownell, K. D. (2012). Positive media portrayals of obese persons: Impact on attitudes and image preferences. *Health Psychology*, 31(6), 821-829.
- Pepper, A. C., & Ruiz, S. Y. (2007). Acculturation's influence on antifat attitudes, body image and eating behaviours. *Eating Disorders: The Journal of Treatment and Prevention*, 15(5), 427-447.
- Peternelj-Taylor, C. A. (1989). The effects of patient weight and sex on nurses' perceptions: A proposed model of nurse withdrawal. *Journal of Advanced Nursing*, 14, 744-754.
- Peternelj-Taylor, C. A. (2004). An exploration of othering in forensic psychiatric and correctional nursing. *Canadian Journal of Nursing Research*, 36(4), 130-146.
- Polit, D. F., & Beck, C. T. (2012). *Nursing research: Generating and assessing evidence for nursing practice*. (9<sup>th</sup> ed.). Philadelphia: Wolters Kluwer Health, Lipincott Williams & Wilkins.

- Pokorny, M. E., Scott, E., Rose, M. A., Baker, G., Swanson, M., Waters, W. G., Watkins, F., & Drake, D. J. (2009). Challenges in caring for morbidly obese patients. *Home Healthcare Nurse: The Journal for the Home Care and Hospice Professional*, 27(1), 43-52.
- Poon, M-Y. & Tarrant, M. (2009). Obesity: Attitudes of undergraduate student nurses and registered nurses. *Journal of Clinical Nursing*, 18, 2355-2365.
- Puhl, R. M., & Brownell, K. D. (2001). Bias, discrimination, and obesity. *Obesity Research*, 9, 788-905.
- Puhl, R. M., & Brownell, K. D. (2003). Ways of coping with obesity stigma: Conceptual review and analysis. *Eating Behaviours*, 4, 53-78.
- Puhl, R. M., & Brownell, K. D. (2006). Confronting and coping with weight stigma: An investigation of overweight and obese adults. *Obesity*, 14(10), 1802-1815.
- Puhl, R. M., & Heuer, C. A. (2009). The stigma of obesity: A review and update. *Obesity*, 17(5), 941-964.
- Rail, G. (2012). The birth of the obesity clinic: Confessions of the flesh, biopedagogies and physical culture. *Sociology of Sport Journal*, 29, 227-253.
- Rand, C. S., & Wright, B.A. (2000). Continuity and change in the evaluation of ideal and acceptable body sizes across a wide age span. *International Journal of Eating Disorders*, 28, 90-100.
- Ray, M. A. (1992). Critical theory as a framework to enhance nursing science. *Nursing Science Quarterly*, 5(3), 98-101.

- Reece, E. A. (2008). Perspectives on obesity, pregnancy and birth outcomes in the United States: The scope of the problem. *American Journal of Obstetrics and Gynecology*, 198(1), 23-27.
- Registered Nurses' Association of Ontario. (2005). *Nursing best practice guidelines: Primary prevention of childhood obesity*. Retrieved on January 15, 2013 from: [www.rnao.org/bestpractices](http://www.rnao.org/bestpractices).
- Reilley, J. J., Methven, E., McDowell, Z., C., Hacking, B., Alexander, D., Stewart, L., & Kelnar, C. J. H. (2003). Health consequences of obesity. *Archives of Disease in Childhood*, 88, 748-752.
- Reto, C. (2003). Psychological aspects of delivering nursing care to the bariatric patient. *Critical Care Nursing Quarterly*, 26(2), 139-149.
- Rich, E., & Evans, J. (2005). Making sense of eating disorders in schools. *Discourse: Studies in the Cultural Politics of Education*, 26(2), 247-262.
- Rigby, N., Leach, R., Lobstein, T., Huxley, R., & Kumanyika, S. (2009). Epidemiology and social impact of obesity. In G. Williams & G. Fruhbeck (Eds.), *Obesity: Science to practice* (pp. 21-44). West Sussex: Wiley- Blackwell.
- Roehling, M. V. (1999). Weight-based discrimination in employment: Psychological and legal aspects. *Personnel Psychology*, 52, 969-1017.
- Rogge, M. M., Greenwald, M., & Golden, A. (2004). Obesity, stigma and civilized oppression. *Advances in Nursing Science*, 27(4), 301-315.
- Rosmond, R. (2004). Aetiology of obesity: a striving after wind? *Obesity Reviews*, 5, 177-181.

- Saguy, A., & Almeling, R. (2008). Fat in the fire? Science, the news media, and the “obesity epidemic”. *Sociological Forum*, 23(1), 53-83.
- Salant, T., & Santry, H. P. (2006). Internet marketing of bariatric surgery: Contemporary trends in the medicalization of obesity. *Social Science & Medicine*, 62, 2445-2457.
- Schmied, V. A., Duff, M., Dahlen, R. M., Mills, A. E., & Kolt, G. S. (2011). ‘Not waving but drowning’: A study of the experiences and concerns of midwives and other health professionals caring for obese childbearing women. *Midwifery*, 27, 424-430.
- Seale, C. (2002). *Media and Health*. London: Sage Publications.
- Seidell, J. C. (2010). Prevalence and trends in adult obesity in affluent countries. In D. Crawford, R. W. Jeffrey, K. Ball & J. Brug (Eds.), *Obesity Epidemiology* (2<sup>nd</sup> ed.) (pp. 17-26). Oxford, NY: Oxford University Press.
- Sender, K., & Sullivan, M. (2008). Epidemics of will, failures of self-esteem: Responding to fat bodies in the biggest loser and what not to wear. *Continuum*, 22, 573-584.
- Shields, M., Carroll, M. D., & Ogden, C. L. (2011). Adult obesity prevalence in Canada and the United States. *National Center for Health Statistics Data Brief*, 56, 1-8.
- Shikora, S. A. (1997). Enteral feeding tube placement in obese patients: Considerations for nutrition support. *Nutritional Clinical Practice*, 12, S9-S13.
- Shugart, H. A. (2011). Heavy viewing: Emergent frames in contemporary news coverage of obesity. *Health Communication*, 26, 635-648.
- Sikorski, C., Riedel, C., Lupp, M., Schulze, B., Werner, P., König, P. W., & Riedel-Heller, S. G. (2012). Perception of overweight and obesity from different angles: A qualitative study. *Scandinavian Journal of Public Health*, 40, 271-277.

- Silverstein, B. A. (2010). Lessons from a morbidly obese nurse patient. *Bariatric Nursing and Surgical Patient Care*, 5(2), 109-112.
- Smith, G. P. (2008). Critical introduction to obesity. In E. M. Blass (Ed.), *Obesity: Causes, mechanisms, prevention and treatment* (pp. 1-17). Sunderland: Sinauer Associates, Inc.
- Sobal, J. (1995). The medicalization and demedicalization of obesity. In D. Maurer & J. Sobal (Eds.), *Eating agendas: Food and nutrition as social problems* (pp. 67-87). Hawthorne: Aldine de Gruyter.
- Sobal, J. (1999). Sociological analysis of the stigmatization of obesity. In J. Germov & L. Williams (Eds.). *A sociology of food and nutrition: The social appetite* (pp.187). Oxford: Oxford University Press.
- Sobal, J., & Stunkard, K. J. (1989). Socioeconomic status and obesity: A review of the literature. *Psychological Bulletin*, 105, 260-275.
- Speakman, J. R., & Levitsky, D. A. (2008). Aetiology of human obesity. In G. Williams & G. Fruhbeck (Eds.), *Obesity Science to Practice* (pp. 186-212). West Sussex: Wiley-Blackwell.
- Strauss, R. S., & Pollock, H. A. (2003). Social marginalization of overweight children. *Archives of Pediatrics and Adolescent Medicine*, 157, 746-752.
- Swinburn, B. A., Egger, G. J., & Raza, F. (1999). Dissecting obesogenic environments: The development and application of a framework for identifying and prioritizing environmental interventions for obesity. *Preventative Medicine*, 29, 563-570.



- Thompson, L., & Kumar, A. (2011). Responses to health promotion campaigns: Resistance, denial and othering. *Critical Public Health, 21*(1), 105-117.
- Thompson, R. L., & Thomas, D. E. (2000). A cross-sectional survey of opinions on weight loss treatments of obese patients attending a diabetic clinic. *International Journal of Obesity and Related Metabolic Disorders, 24*(2), 164-170.
- Thorne, S. (2000). Data analysis in qualitative research. *Evidence Based Nursing, 3*, 68-70.
- Torrance, G. M., Hooper, M. D., & Reeder, B. A. (2002). Trends in overweight and obesity among adults in Canada (1970-1992): Evidence from national surveys using measured height and weight. *International Journal of Obesity, 26*(6), 797-804.
- Tracy, S. J. (2010). Qualitative quality: Eight “big-tent” criteria for excellent qualitative research. *Qualitative Inquiry, 16*(10), 837-851.
- Tremblay, M. S., Katzmarzyk, P. T., & Willms, J. D. (2002). Temporal trends in overweight and obesity in Canada 1981-1996. *International Journal of Obesity, 26*, 538-543.
- Vacek, L. (2007). Sensitivity training for nurses caring for morbidly obese patients. *Bariatric Nursing, 2*(4), 251-253.
- Warner, J., & Gabe, J. (2004). Risk and liminality in mental health social work. *Health, Risk and Society, 6*, 387-399.
- Wee, C. C., Phillips, R. S., Cook, E. F., Haas, J.S., Puopolo, A. L., Brennan, T. A., & Burstin, A. R. (2002). Influence of body weight on patients' satisfaction with ambulatory care. *Journal of General Internal Medicine, 17*(2), 155-159.

- Weeks, M. (2005). Nurse Physician Communication in the Perioperative Environment: Discourse and Actions to Transform Health Care. *Canadian Operating Room Nursing Journal*, 23(1), 48-56.
- Westerholm, K. (2009). Encountering the Other through ongoing cultural learning: A teaching-learning model from the humanbecoming perspective. *Nursing Science Quarterly*, 22(3), 221-227.
- Whitehead, E., Carlisle, C., Watkins, C., & Mason, T. (2001). Chapter 2: Historical developments. In T. Mason, C. Carlisle, C. Watkins & E. Whitehead (Eds.), *Stigma and social exclusion in health care* (pp. 17-28). London: Routledge.
- Whitefield, P. J., & Grassley, J. (2008). Nurses' experiences of caring for postoperative bariatric patients. *Bariatric Nursing and Surgical Patient Care*, 3(4), 291-298.
- World Health Organization. (2000). *Obesity: Preventing and managing the global epidemic- WHO Technical Report Series 894*. Geneva: World Health Organization. Retrieved on December 2, 2012 from:  
[http://ww.who.int/nutrition/publications/obesity/WHO\\_TRS\\_894/en/index.html](http://ww.who.int/nutrition/publications/obesity/WHO_TRS_894/en/index.html)
- World Health Organization. (2006). *Factsheet 311*. Retrieved on December 2, 2012 from:  
<Http://www.who.int/mediacentre/factsheets/fs311/en/index.html>.
- World Health Organization. (2011). *World Health Organization- Controlling the global obesity epidemic*. Retrieved on December 2, 2012 from:  
<http://www.who.int/nutrition/topics/obesity/en/>
- World Health Organization (2012). *Obesity and overweight fact sheet No 311*. Retrieved on December 2, 2012 from: <http://www.who.int/mediacentre/factsheets/fs311/en/>

- Wray, S., & Deery, R. (2008). The medicalization of body size and women's health care. *Health Care for Women International, 29*, 227-243.
- Wright, J. (1998). Female nurses' perceptions of acceptable female body size: An exploratory study. *Journal of Clinical Nursing, 7*, 307-315.
- Wright, K., Haigh, K., & McKeown, M. (2007). Reclaiming the humanity in personality disorder. *International Journal of Mental Health Nursing, 16*, 236-246. Retrieved on December 1, 2012 from <http://www.sciencedirect.com/science/article/pii/S0277953067000421>
- Wykes, M., & Gunter, B. (2005). *The media and body image: If looks could kill*. London: Sage Publications.
- Zuzelo, P. (2005). Bariatric patient care BASICS: Bias, airway, skin, incontinence, chronicity and safety. *The Pennsylvania Nurse, 18-19*.
- Zuzelo, P. R., & Seminara, P. (2006). Influence of registered nurses' attitudes towards bariatric patients on educational programming effectiveness. *The Journal of Continuing Education in Nursing, 37*(2), 65-73.

**Appendix A. Research Ethics Board Approvals**



**Research Ethics Boards / Conseils d'éthique en recherches**

April 15, 2013

Ms. Jacqueline Shea

Dear Ms. Shea:

**Re: Protocol # 20130095-01H Working with the obese patients in the intensive care unit (ICU): A study of nurses' experiences.**

**Protocol approval valid until - April 14, 2014**

I am pleased to inform you that this protocol underwent delegated review by the [REDACTED] Research Ethics Board [REDACTED] and is approved. No changes, amendments or addenda may be made to the protocol or the consent form without the [REDACTED]'s review and approval.

Approval is for the following:

- Thesis Proposal Document, dated January 2013
- English and French Posters, version 1, dated April 03, 2013
- English Information/Consent Form, version 1, dated April 09, 2013
- French Information/Consent Form, version 1, dated January 23, 2013
- English and French Pre-Interview Questionnaire, version 1, dated April 03, 2013
- English-Only, Interview Guide, version 1, dated April 03, 2013

The validation date should be indicated on the bottom of all consent forms and information sheets (see copy attached). If the study is to continue beyond the expiry date noted above, a Renewal Form should be submitted to the [REDACTED] approximately six weeks prior to the current expiry date. If the study has been completed by this date, a Termination Report should be submitted.

The [REDACTED] Research Ethics Board is constituted in accordance with, and operates in compliance with the requirements of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans; Health Canada Good Clinical Practice: Consolidated Guideline; Part C Division 5 of the Food and Drug Regulations of Health Canada; and the provisions of the Ontario Health Information Protection Act 2004 and its applicable Regulations.

Yours sincerely,

[REDACTED]

File Number: H04-13-14

Date (mm/dd/yyyy): 05/14/2013



**Université d'Ottawa** **University of Ottawa**  
 Bureau d'éthique et d'intégrité de la recherche Office of Research Ethics and Integrity

**Ethics Approval Notice**  
**Health Sciences and Science REB**

**Principal Investigator / Supervisor / Co-investigator(s) / Student(s)**

<u>First Name</u>	<u>Last Name</u>	<u>Affiliation</u>	<u>Role</u>
Marilou	Gagnon	Health Sciences / Nursing	Supervisor
Jacqueline	Shea	Health Sciences / Nursing	Student Researcher

File Number: H04-13-14

Type of Project: Master's Thesis

Title: Working with the obese patients in the intensive care unit (ICU): A study of nurses' experiences

<u>Approval Date (mm/dd/yyyy)</u>	<u>Expiry Date (mm/dd/yyyy)</u>	<u>Approval Type</u>
05/14/2013	05/13/2014	Ia

(Ia: Approval, Ib: Approval for initial stage only)

**Special Conditions / Comments:**  
 N/A

**Appendix B.** Recruitment Posters

## **WORKING WITH OBESE PATIENTS IN THE INTENSIVE CARE UNIT (ICU): A STUDY OF NURSES' EXPERIENCES**

**Are you a registered nurse?**

**Are you presently working in an intensive care unit?**

**Have you cared for at least one obese patient in the ICU?**

We are looking for registered nurses to take part in a study on the experience of working with obese patients in the intensive care unit.

As a participant, you will be asked to take part in a 60 minute interview. This interview will be conducted in English.

For more information or to volunteer for this study, please contact : Jacqueline Shea, RN, MScN (candidate)

Phone : [REDACTED]

E-mail: [REDACTED]

*This research study has been approved by [REDACTED] Research Ethics Board*



**uOttawa**

Faculté des sciences de la santé  
Faculty of Health Sciences

École des sciences infirmières

School of Nursing



# **PRENDRE SOINS DES PERSONNES OBÈSES AUX SOINS INTENSIFS: UNE ÉTUDE SUR L'EXPÉRIENCE DES INFIRMIÈRES ET INFIRMIERS**

**Êtes-vous un(e) infirmier(ère) autorisé(e)?  
Travaillez-vous actuellement aux soins intensifs?  
Avez-vous déjà pris soin d'une personne obèse aux  
soins intensifs?**

Nous cherchons des participants(es) pour prendre part à une étude qui porte sur l'expérience des infirmiers et infirmières qui prennent soin de personnes obèses aux soins intensifs.

En tant que participant(e) vous prendrez part à une entrevue de 60 minutes. Cette entrevue se déroulera en anglais.

Pour plus d'information ou pour participer à cette étude, veuillez communiquer avec : Jacqueline Shea, inf.aut.,  
M.Sc.Inf (candidate)

Téléphone : [REDACTED]

Courriel: [REDACTED]

*Cette étude a été approuvée par le Conseil d'éthique en recherches de*  
[REDACTED]

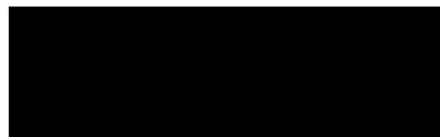


**uOttawa**

Faculté des sciences de la santé  
Faculty of Health Sciences

École des sciences infirmières

School of Nursing



**Appendix C. Pre-Interview Questionnaire**

### Pre-Interview Questionnaire

The following questionnaire will be filled by participants before the interview. The data collected will be used to describe the sample and will not be used for analytic purposes.

#### English version

1) What is your age?

- 20-24
- 25-29
- 30-34
- 35-39
- 40-44
- 45-49
- 50-54
- 55-59
- 60-64
- > 65

2) Are you:

- A male
- A female

3) What is highest level of diploma or degree you have attained in Nursing?

- College Diploma
- Bachelor Degree
- Master's Degree
- Doctoral Degree

4) How many years of clinical experience do you have as a registered nurse?

- Less than 5 years
- 5-9 years
- 10 to 14 years
- 15 to 19 years
- Greater than 20 years

5) How many years of clinical experience do you have as an intensive care nurse?

- Less than 2 years
- 2-4 years
- Greater than 5 years

French version

1) Quel âge avez-vous?

- 20-24
- 25-29
- 30-34
- 35-39
- 40-44
- 45-49
- 50-54
- 55-59
- 60-64
- > 65

2) Êtes-vous :

- Un homme
- Une femme

3) Quel est le niveau de scolarité le plus élevé que vous avez atteint en sciences infirmières?

- Diplôme d'études collégiales
- Baccalauréat
- Maîtrise
- Doctorat

4) Combien d'années d'expérience avez-vous à titre d'infirmière autorisée?

- Moins de 5 années
- 5-9 années
- 10 à 14 années
- 15 à 19 années
- Plus de 20 années

5) Combien d'années d'expérience avez-vous à titre d'infirmière autorisée aux soins intensifs?

- Moins de 2 années
- 2-4 années
- Plus de 5 années

**Appendix D. Interview Guide**

### Interview Guide

During the interview process, participants will be asked to describe their experiences as intensive care nurses caring for patients that are obese and how these experiences influence the way they provide care in the intensive care unit (ICU). They will be encouraged to expand on the strategies developed to care for obese patients and identify areas of improvement in the ICU.

#### Overall Experience

Describe your overall experience working with obese patients in the ICU.

#### Specific Experiences

Describe an experience that stands out for you (positive or negative).

Probe: What did you learn from that experience?

Probe: What was challenging about that experience?

Probe: How did that experience change or affect your practice as an ICU nurse?

#### Nursing Care

Describe what a 12 hour shift is like when providing care to an obese patient in the ICU.

Probe: What are the specific needs of obese patients in the ICU?

Probe: What are the clinical and practical considerations when taking care of an obese patient?

Probe: How is the nursing care different from nursing care provided to non-obese patients?

#### Context

Describe the supports you have on the unit when providing care to obese patients.

Probe: What supports are useful and why?

Probe: What supports do you feel are lacking?

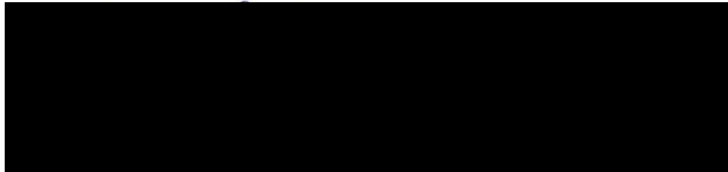
Probe: How would you describe the impact of these supports in practice?

**Appendix E. ICU Research Committee Consent**

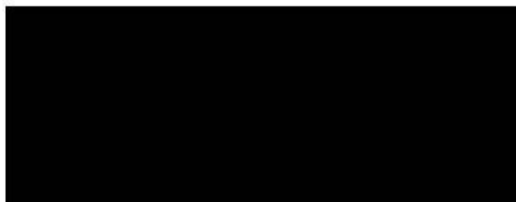
December 6, 2012

Re: Working with the obese: A qualitative study

I, Dr. [REDACTED] and the ICU research committee approve the qualitative research study on nurses' attitudes and perceptions of obese patients. The research study will be conducted by Jacqueline Shea RN and MScN candidate. The research study may take place at the [REDACTED] intensive care units.



**Appendix F. Consent Forms**



### INFORMATION/CONSENT FORM

**Project title:** Working with obese patients in the intensive care unit: A study of nurses' experiences

**Researcher:** Jacqueline Shea, RN, MScN (candidate)  
 School of Nursing  
 Faculty of Health Sciences  
 University of Ottawa

**Supervisor:** Marilou Gagnon, RN, PhD  
 Assistant Professor  
 School of Nursing  
 Faculty of Health Sciences  
 University of Ottawa

#### Introduction

You are being asked to participate in this study because you are a nurse who has worked with obese patients in the Intensive Care Unit (ICU). This document will inform you about the nature of the research project and the type of participation required. In addition, the consent form provides you with an opportunity to clarify your rights as a study participant and to understand how the researcher will ensure these rights throughout the study. Please note that the researcher is available at all times to answer questions and if needed, to clarify the information contained in this document.

#### Goal of the study

The goal of this study is to explore the experiences of intensive care nurses caring for obese patients. This study aims to better understand how ICU nurses care for their obese patients as well as to discuss the positive and negative encounters that nurses have experienced. 12 nurses at [redacted] will be recruited to participate in this study, which is being conducted in English only.

#### Participation

If you consent, you will participate in one face to face interview, at a mutually convenient time, at the University of Ottawa. The interview will last approximately 60 minutes and will be audio recorded, with your permission. If you do not wish to be recorded, notes will be taken during the

interview instead. You may skip any question during the interview that you are not comfortable answering.

### **Risks**

There are no known risks associated with participation in this study.

### **Benefits**

Participation in this study will help contribute to the development of knowledge in the field of ICU nursing and the improvement of clinical care provided to obese patients in ICU settings. This study is an opportunity to share experiences as an intensive care nurse working with obese patients and to identify needs as a clinician (support, training, guidelines, etc.).

### **Confidentiality and anonymity**

All personal information will be kept confidential, unless release is required by law. Representatives of the [REDACTED] Research Ethics Board, as well as the [REDACTED], may review the study records under the supervision of the investigator for audit purposes.

You will not be identifiable in any publications or presentations resulting from this study. No identifying information will leave The [REDACTED] or the University of Ottawa. All information which leaves the hospital will be coded with an independent alphanumeric code.

The document that lists your name and the independent alphanumeric code will only be accessible by the researcher (Jacqueline Shea) and her thesis advisor (Marilou Gagnon). The link and study files will be stored separately and securely. Both files will be kept for a period of 10 years after the study has been completed. All paper records will be stored in a locked unit. All electronic records will be stored on an encrypted laptop and protected by a user password, again only accessible by Jacqueline Shea and Marilou Gagnon. The audio recordings will be deleted immediately upon transcription. At the end of the retention period all paper records will be disposed of in confidential waste or shredded, and all electronic records will be permanently deleted.

### **Withdrawal from the study**

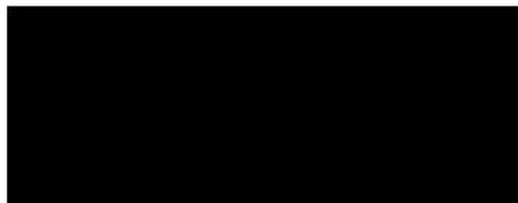
Participation in this research study is voluntary. If you withdraw from the study, the content of the interview will be destroyed and will not be used in the analyses. The decision to participate or not, will have no effect on your current or future employment within The Ottawa Hospital.

### **Questions regarding the study**

If you have any questions regarding this study (before, during or after), please contact Jacqueline Shea by phone [REDACTED] or by e-mail: [REDACTED].

### **Ethics**

This research project has been approved by [REDACTED] Research Ethics Board and the University of Ottawa Research Ethics Board. If you have any questions regarding the ethical aspect of this study or your rights as a research participant, you may contact the Chairperson of [REDACTED] or the ethics advisor at the University of Ottawa: University of Ottawa, Pavillon Tabaret, 550 Cumberland Street, room 154, Ottawa, ON K1N 6N5; (613) 562-5387; ethics@uottawa.ca.



**Project Title:** Working with obese patients in the intensive care unit: A study of nurses' experiences

**Consent to Participate In Research**

I understand that I am being asked to participate in a research study about the experiences of ICU nurses providing care to obese patients in hospital. This study has been explained to me by the researcher (Jacqueline Shea).

I have read this document (Information Sheet and Consent Form - 3 pages) or have had this document read to me. All my questions have been answered to my satisfaction. If I decide at a later stage in the study that I would like to withdraw my consent, I may do so at any time.

I voluntarily agree to participate in this study.

A copy of the signed Information Sheet / Consent Form will be provided to me.

I consent to be audio-recorded: yes  no

I consent to be quoted directly (any identifying information will be removed): yes  no

**Signatures**

Participant's Name (Please Print) \_\_\_\_\_

Participant's Signature \_\_\_\_\_

Date \_\_\_\_\_

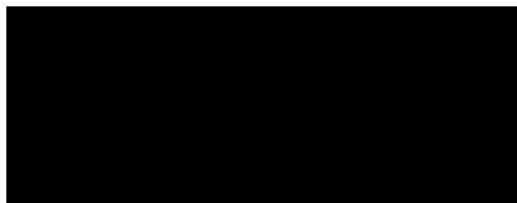
**Investigator Statement (or Person Explaining the Consent)**

I have carefully explained to the research participant the nature of the above research study. To the best of my knowledge, the research participant signing this consent form understands the nature, demands, risks and benefits involved in participating in this study. I acknowledge my responsibility for the well-being of the above research participant, to respect the rights and wishes of the research participant, and to conduct the study according to research standards.

Name of Investigator (Please Print) \_\_\_\_\_

Signature of Investigator \_\_\_\_\_

Date \_\_\_\_\_



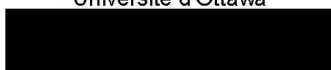
## FORMULAIRE DE CONSENTEMENT/D'INFORMATION

**Titre du projet :** Prendre soins des personnes obèses aux soins intensifs : Une étude sur l'expérience des infirmiers(ères)

**Chercheure :** Jacqueline Shea, Inf., MScIn (candidate)  
École des sciences infirmières  
Faculté des sciences de la santé  
Université d'Ottawa



**Superviseure:** Marilou Gagnon, Inf., PhD  
Professeure adjointe  
École des sciences infirmières  
Faculté des sciences de la santé  
Université d'Ottawa



### Invitation à participer à cette étude

Vous êtes invité à participer à la présente étude car vous êtes infirmier(ère) aux soins intensifs et que vous avez déjà pris soins de personnes obèses dans ce milieu clinique. Ce document vise à vous informer de la nature du projet de recherche et de votre participation. De plus, le formulaire de consentement vous offre l'opportunité de clarifier vos droits en tant que participant et de vous informer des moyens utilisés par la chercheure afin de respecter ces mêmes droits. Veuillez noter que la chercheure est en tout temps disponible pour répondre à vos questions et au besoin, pour clarifier les informations contenues dans ce document.

### But de l'étude

Le but de cette étude est d'explorer les expériences des infirmiers(ères) qui prennent soins de personnes obèses aux soins intensifs. Cette étude a également pour but de mieux comprendre comment les infirmiers(ères) prennent soins de ces personnes et d'aborder les expériences positives et négatives que vivent les infirmiers(ères). 12 infirmier(ères) seront recrutés au [redacted] pour prendre part à cette étude qui se déroulera en anglais seulement.

### Nature de votre participation

Si vous consentez à cette étude, vous prendrez part à une seule entrevue face-à-face avec la chercheure à l'Université d'Ottawa à un moment qui vous convient. Il est prévu que cette entrevue durera environ 60 minutes et que vos propos seront enregistrés sur bande audio avec

votre permission. Si vous préférez ne pas être enregistré, des notes seront prises pendant l'entrevue. Vous pouvez choisir de ne pas répondre à certaines questions pendant l'entrevue si elles vous rendent inconfortable.

### **Risques**

Il n'y a pas de risque connu associé à la participation à cette étude.

### **Bienfaits**

En participant à cette étude, vous contribuerez à l'avancement des connaissances dans le domaine des soins intensifs et l'amélioration des soins offerts aux personnes obèses dans les milieux de soins intensifs. Il s'agit d'une opportunité de partager mes expériences en tant qu'infirmier(ère) qui prend soins de personnes obèses aux soins intensifs et mes besoins en tant que clinicienne (soutien, formation, ligne directrices, etc.).

### **Confidentialité et anonymat**

Toute information personnelle sera maintenue confidentielle, à moins que la divulgation de cette information ne soit exigée par la loi. Des représentants des comités d'éthique de la recherche de [REDACTED] peuvent demander à revoir les documents liés à cette étude sous la supervision de la recherche à des fins de vérifications.

Vous ne serez pas identifiable lors de la publication et la présentation des résultats de cette étude. Aucune information permettant votre identification quittera [REDACTED] ou l'Université d'Ottawa. Toute information qui quitte l'hôpital sera identifiée au moyen d'un code alphanumérique.

Seules la chercheuse (Jacqueline Shea) et sa superviseure de thèse (Dr. Marilou Gagnon) auront accès au document où figurent votre nom et le code alphanumérique indépendant. Ce document et tout autre document concernant cette étude seront conservés séparément et en toute sécurité. Ces documents seront conservés pendant une période de 10 ans après la fin de l'étude. Les documents papiers seront conservés dans des filières sous clé. Les documents électroniques seront conservés dans un ordinateur encrypté et protégé par un mot de passe. Seule la chercheuse et sa superviseure auront accès à ces documents. Une fois la période de conservation terminée, les documents papiers seront déchiquetés de façon confidentielle et les documents électroniques seront effacés de façon permanente.

### **Retrait de l'étude**

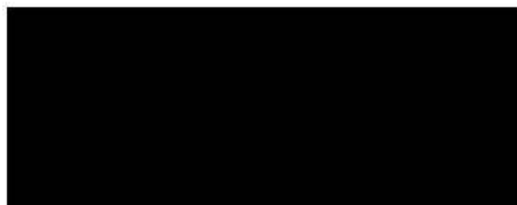
Il est entendu que votre participation au projet de recherche décrit ci-dessus est tout à fait libre. Il est également entendu que je peux, à tout moment, mettre un terme à ma participation sans que cela ne me cause préjudice au niveau de mon emploi ou future emploi avec [REDACTED]. Les données amassées lors de mon entrevue seront alors détruites (fichiers audio coupés et transcriptions déchiquetées) et ne seront pas utilisées pour la recherche.

### **Questions à propos de l'étude**

Si vous avez des questions à propos de cette étude (avant, pendant ou après), veuillez contacter Jacqueline Shea par téléphone [REDACTED] ou courriel [REDACTED].

### Éthique

Ce projet de recherche a été approuvé par les Comités d'éthique à la recherche de [REDACTED] et de l'Université d'Ottawa. Pour toute question éthique concernant les conditions dans lesquelles se déroule ma participation à ce projet, je peux à tout moment communiquer mes préoccupations au responsable de l'éthique en recherche à [REDACTED] ou à l'Université d'Ottawa, Pavillon Tabaret, 550, rue Cumberland, salle 154, Ottawa, ON K1N 6N5; Tél.: (613) 562-5387; courriel: [ethics@uottawa.ca](mailto:ethics@uottawa.ca).



### **Formulaire de consentement**

Je comprends qu'on me demande de prendre part à une étude sur les expériences des infirmiers(ères) de soins intensifs qui prennent soins de personnes obèses. Cette étude m'a été expliquée par la chercheure (Jacqueline Shea).

J'ai lu attentivement ce document (feuillet d'information et formulaire de consentement – 4 pages) ou je confirme qu'on m'a lu ce document. On a répondu à toutes mes questions de façon satisfaisante. Je comprends que je puis retirer mon consentement et interrompre ma participation à tout moment, sans conséquences négatives.

Je consens libre et volontaire à participer à cette étude.

Une copie signée du feuillet d'information / formulaire de consentement me sera remise.

J'accepte d'être enregistrée sur bande audio : oui  non

J'accepte que mes propos puissent être cités de manière intégrale (les informations qui se rapportent à mon identité seront retirés): oui  non

### **Signatures**

\_\_\_\_\_  
Nom du(de la) participant(e) (en lettres moulées)

\_\_\_\_\_  
Signature du(de la) participant(e)

\_\_\_\_\_  
Date

### **Énoncé de la chercheure**

J'ai soigneusement expliqué au(à la) participant(e) la nature de cette étude. Au meilleur de mes connaissances, le(la) participant(e) qui signe ce formulaire de consentement comprend la nature, les exigences, les risques et les bénéfices qu'implique la participation à cette étude. Je reconnais mes responsabilités en ce qui concernent le soin et le bien-être du(de la) participant(e) en question, le respect de ses droits et volontés, et le déroulement de cette étude selon les normes de la recherche.

Nom de la chercheure (en lettres moulées) \_\_\_\_\_

Signature de la chercheure \_\_\_\_\_