SOCIAL JUSTICE IN THE CLINIC: CARING FOR LARGER PATIENTS

by

DEANA KANAGASINGAM

B.A., University of Toronto, 2008
M.A., University of Toronto, 2010

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The following individuals certify that they have read, and recommend to the Faculty of Graduate and Postdoctoral Studies for acceptance, the dissertation entitled:

Social justice in the clinic: caring for larger patients

Submitted by Deana Kanagasingam in partial fulfilment of the requirements for the degree of Doctor of Philosophy in Kinesiology

Examing Committee:

Laura Hurd, Professor, Kinesiology, UBC
Co-supervisor
Moss Norman, Associate Professor, Kinesiology, UBC
Co-supervisor
Jennifer Black, Associate Professor, Food, Nutrition and Health, UBC
University Examiner
Laura Nimmon, Associate Professor, Occupational Science and Occupational Therapy, UBC
University Examiner

Additional Supervisory Committee Members:

Robert Woollard, Professor, Family Practice, UBC
Supervisory Committee Member
Abstract

Many larger patients experience weight-based discrimination in healthcare settings, and are judged by practitioners as irresponsible and non-compliant (Phelan et al., 2014). Though there has been increased attention on how weight-based discrimination jeopardizes patient health outcomes (Sutin et al., 2015), empirical research is lacking on 1) practitioners who adopt a social justice approach to caring for larger patients or 2) larger patients’ experiences of receiving social justice-informed care. Social justice in practice refers to addressing intersecting macro-level inequities such as racism, sexism, and sizeism through micro-level practitioner-patient interactions (Mishler, 2005). The present study fills a research gap by examining how social justice is understood, enacted, and experienced in weight-related clinical interventions. Drawing on one-on-one interviews with 22 diverse healthcare practitioners who identify as social justice advocates and 20 larger patients served by such practitioners, four main questions were addressed: 1) How do participants understand social justice? 2) How do practitioners translate social justice principles into practice? 3) What challenges do practitioners encounter when practicing social justice? 4) How does social justice-informed care shape larger patients’ experience? The findings reveal that participants rejected the notion of obesity as an individual problem, and demonstrated a deep awareness of the broader social factors shaping weight and overall wellbeing. Nonetheless, participants’ approaches to care differed depending on whether they regarded obesity as either primarily a social construct or a biomedical fact. Furthermore, despite the prevailing paradigm of obesity as a disease, participants conveyed that non weight-related factors such as financial strain and racism more profoundly impacted patients’ health, which casts doubt on whether medicalizing obesity truly benefits larger patients. A social justice informed-approach to care was found to enhance patients’ experience, with patients expressing
appreciation for having their trauma histories and social challenges handled with compassion and curiosity. The study highlights the need to integrate micro-level strategies for individual healing with a macro-level framework of systemic change, as well as cultivate in patients, clinicians, and the public at large a more nuanced understanding of weight and health. The findings provide practice-oriented insights for care informed by frameworks of weight-inclusivity, structural competency, and person-centredness.
Lay Summary

The study examines how social justice is understood, enacted, and experienced in clinical care for larger patients. Interviews were conducted with 22 clinicians who described themselves as social justice oriented and 20 larger patients under their care. Participants rejected the notion of obesity as an individual problem, and demonstrated an awareness of the broader social factors shaping weight and overall wellbeing. Nonetheless, participants’ approaches to care differed depending on whether they understood obesity as either a socially created label or an objective truth. Despite the prevailing disease model of obesity, participants identified factors beyond weight such as financial strain and racism as affecting patient health more significantly. Patients expressed appreciation for social justice-informed care that accounted for their trauma histories and social challenges. The study highlights the need to combine individual-level healing with systemic change and promote more nuanced understandings of weight and health, which can potentially guide healthcare practice.
Preface

This research was approved by the University of British Columbia’s Behavioural Research Ethics Board (H20-01979).

The PhD dissertation is divided into three articles, which have been submitted for publication to different academic journals. Study 1 is represented in Chapter 5. A version of this work has been published in Social Science and Medicine - Qualitative Research in Health on July 21, 2022. Please see the online version here: https://www.sciencedirect.com/science/article/pii/S2667321522000993. I am the sole author of this manuscript. Dr. Laura Hurd, Dr. Moss Norman, and Dr. Robert Woollard provided inputs on the study design and recruitment. Dr. Hurd and Dr. Norman also gave feedback on the data interpretation and writing. I was responsible for study design, participant recruitment, data collection and analysis, and manuscript preparation.

Study 2 is represented in Chapter 6. A version of this work was published in Sociology of Health and Illness on April 17, 2022. Please see the online version here: https://onlinelibrary.wiley.com/doi/10.1111/1467-9566.13470. Dr. Moss Norman and Dr. Laura Hurd are the co-authors of this manuscript, and were involved in the study design, data interpretation, and manuscript editing. Dr. Robert Woollard provided inputs on the study design and recruitment. I was responsible for study design, participant recruitment, data collection and analysis, and manuscript preparation.

Study 3 is represented in Chapter 7. A version of this work has been submitted to an academic journal for review, and feedback has been received from the reviewers. The third round of revisions have been completed and the manuscript was re-submitted on September 22, 2022. Dr. Moss Norman and Dr. Laura Hurd are the co-authors of this manuscript, and were involved
in the study design, data interpretation, and manuscript editing. Dr. Robert Woollard provided inputs on the study design and recruitment. I was responsible for study design, participant recruitment, data collection and analysis, and manuscript preparation.
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<td>BMI</td>
<td>Body Mass Index</td>
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<tr>
<td>HAES</td>
<td>Health at Every Size</td>
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<td>EBM</td>
<td>Evidence Based Medicine</td>
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<tr>
<td>EBP</td>
<td>Evidence Based Practice</td>
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<td>PCC</td>
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Chapter 1: Introduction

Weight stigma is pervasive in healthcare settings, evident in how many health practitioners blame and shame heavier patients for their weight, undermining patient dignity and quality of life (Phelan et al., 2014). While the concept of weight stigma has not been used consistently in the literature, I refer to weight stigma as an umbrella term encompassing a) negative beliefs, attitudes, and stereotypes about people’s body size, shape, weight, and amount/distribution of adipose tissue (i.e. weight bias) and b) unjust treatment and behaviours that are fuelled by such bias (i.e. weight-based discrimination) (Campbell, 2021). These discriminatory practices manifest both overtly and covertly, in the form of weight-based bullying, harassment, exclusion, and microaggressions (e.g., questioning a larger person’s food and activity choices) (Calogero et al., 2016). Weight stigma can be situated within Link and Phelan’s (2001) broader concept of stigma, which posits that “stigma exists when elements of labelling, stereotyping, separation, status loss, and discrimination occur together in a power situation that allows them” (p. 377). Watson and Eack (2010) describe how this process begins when labels are used to classify human difference. Such labels, which are often imbued with negative qualities, in turn create and reinforce a binary between ‘us’ (the normal) and ‘them’ (the stigmatized). The stigmatized are then positioned lower within a status hierarchy, and experience disadvantages in various spheres of life including income, education, and healthcare (Watson & Eack, 2010). This emphasis on power relations highlights that the exercise of power is fundamental to the process of stigmatization (Watson & Eack, 2010). Thus, an understanding of weight stigma must expand beyond micro-level personal and interpersonal contexts, to systemic oppression, which is defined as the ways in which social norms, ideologies, laws, and
institutions, work in tandem to perpetuate inequity (Prohaska & Gailey, 2019; Watson & Eack, 2010).

Within the domain of healthcare, weight bias has been found in a range of healthcare practitioners and trainees including doctors (Sabin et al., 2012), nurses (Mulherin et al., 2013), exercise science students (Chambliss et al., 2004), physiotherapists (Setchell et al., 2015), and dieticians (Stone & Werner, 2012). Practitioners who hold such prejudicial attitudes tend to attribute obesity to a lack of personal control and conflate weight management with moral worth, revealing an individualistic ideology that places responsibility for health solely within the hands of patients (LeBesco, 2011; Nutter et al., 2016). Healthcare providers with weight bias have been reported to build less emotional rapport, display less patience, shorten appointment durations, provide less health education, and hesitate to perform certain screenings with larger patients as compared to thinner patients (Hebl & Xu, 2001; Pausé, 2014; Puhl et al., 2016).

The experience of weight stigma negatively impacts a range of patient health outcomes, even after controlling for Body Mass Index (BMI), suggesting that the harms of stigma can be more detrimental than excess weight in itself (Sutin et al., 2015). The outcomes of stigma include an increased risk of mental health issues, disordered eating habits, reduced physical activity, healthcare avoidance (Drury & Louis, 2002; Puhl, 2010), poorer management of chronic disease, and increased functional disability (Potter et al., 2015; Schafer & Ferraro, 2011). Weight stigma also leads to poor socio-economic outcomes such as reduced income and other employment-related outcomes, including hiring decisions and promotability ratings (Roehling et al., 2013; Vanhove & Gordon, 2014), as well as increased risk of poverty (Ernsberger, 2009) and unemployment (Morris, 2007).
Given the prevalence of weight stigma and its wide-reaching consequences for wellbeing, two major perspectives in the field of healthcare have emerged to address such injustice. The first, a “macro ethics of social justice” (Mishler, 2005, p. 432), pays attention to various spheres of social life such as race, gender, class, the environment (Rogers & Kelly, 2011). Social justice can be defined as the distribution of goods, services, opportunities, and rights within a societal context that maximizes individuals’ capacities, meets their diverse needs, and ensures their psychological and physical safety and security (Russell-Mayhew, 2006). In the context of health and weight, social justice emphasizes the principles of equity in areas such as health literacy, access to a safe environment and quality food, and recreational opportunities (Azétsop & Joy, 2011). It also recognizes that many of these factors are beyond the control of individuals, especially those belonging to marginalized, non-dominant groups, and thus regards individualistic blaming and shaming approaches to health as being socially unjust (Azétsop & Joy, 2011). While the macro ethics of social justice highlights the oppressive social structures that affect human flourishing, it gives less attention to the micro-level experience, particularly the encounters between patients and practitioners (Mishler, 2005).

The second perspective, a “micro-ethics of humane care” (Mishler, 2005, p. 432), highlights the importance of developing interpersonal skills in practitioners that allow them to enter the world of patients and attend to their needs. This approach seeks to enhance the quality of micro-level patient-practitioner relations by treating each patient as a unique, whole, and autonomous individual. It focuses on understanding health as holistic or involving a mind-body connection, responding to patients with warmth and empathy, and involving patients in decisions about their care (Mishler, 2005). While this approach humanizes the patient and attends to their subjective experiences, it tends to neglect the role of systemic biases and structural inequities.
(Metzl et al., 2018). Accordingly, it may reinforce the assumption that individual compliance with health directives such as monitoring calorie intake and increased physical activity would eradicate the problem of obesity (Gard & Wright, 2005).

There remains a lack of critical dialogue within the healthcare field between the macro-ethics of social justice and the micro-ethics of humane care, particularly in relation to weight-related treatment. Most of the research on obesity tends to adopt an individualistic approach, though some research has focused on integrating social justice into obesity preventive health efforts (Piran, 2015). Researchers have highlighted best practices informed by social justice for obesity prevention, such as providing a combined focus on nutrition and physical activity without a weight focus (Katz et al., 2008; Russell-Mayhew et al., 2012) and modifying the factors that impact social and physical environments affecting nutrition and physical activity (Neumark-Sztainer et al., 2006; Russell-Mayhew et al., 2007). However, less is known about how social justice can be used as a framework to understand micro-level interpersonal interactions between practitioners and larger patients. To my knowledge, to-date there have been no empirical studies on healthcare practitioners who adopt a social justice approach to caring for larger patients. To fill this research gap and present an alternative to the dominant paradigm of obesity treatment, I feature the perspectives of healthcare practitioners across multiple professions who describe themselves as adopting a social justice approach to caring for larger patients, as well as with self-identified larger patients of these practitioners. Patients’ narratives allow me to examine the impact of social justice efforts on patients’ quality of care and what kind of care they desire most. I conducted one-on-one in-depth interviews with a total of 42 participants in Canada – 22 healthcare practitioners comprising physicians, dieticians, and mental health professionals; and 20 larger patients served by these healthcare practitioners.
1.1 Research Questions

The interview guide was designed around four main questions pertaining to interactions between practitioners and larger patients.

1) What does social justice mean to practitioners and patients?

2) How do practitioners translate principles of social justice into concrete practices and behaviours when interacting with larger patients?

3) What are the challenges of practicing social justice that practitioners encounter when working with larger patients?

4) How does social justice-informed care impact larger patients’ experience?

1.2 Self-Reflexivity

My interest in studying weight and social justice in healthcare stems from my personal and professional experience. On a personal level, I seek to challenge fat oppression because I have observed how pervasive and destructive it is, both in Singapore, where I grew up, and Canada, where I am currently located. I believe that fat phobia affects everyone, albeit in different ways, and not just those who are medically defined as fat. I have never had what was deemed a high BMI but through my teenage years and 20s, I struggled with body image and disordered eating in my quest to fight fat. I regard the fear of fat as being intimately intertwined with race, class, and gender (Strings, 2019). My struggles with weight started during adolescence, where I first experienced myself as a racialized, classed, and gendered body. I attended an all-girls school in Singapore with students who were primarily from a higher socioeconomic background. As members of an elite educational institution, we were expected to translate all the knowledge we acquired into healthy behaviours that would manifest in a thin body. As a teenager, I learnt the powerful message that thinness was associated with a dominant...
racial and class position in society and that women, more so than men, would be demonized for being fat. My body was the first thing I learnt how to control when I felt disempowered in other life domains. When I experienced racism and bullying, I strived to control my body to gain a sense of power, however fleeting. However, despite my best attempts, I was not always successful at controlling my unruly body, and I realized how devasting it was to feel unable to control what I so desperately wanted to, and to feel denigrated by others for this failure.

The professional experience I acquired later on in life deepened my understanding of weight as a social justice issue. Prior to pursuing graduate studies at UBC, I worked as an administrator in the field of public health in Singapore, where I developed tobacco control programs to serve the needs of populations deemed at-risk. During the course of my work, I witnessed how a social justice lens was lacking in public health. Typically, when we discussed the social determinants of health, the concept was invoked as a means to a narrowly defined end – we pinpointed the specific determinants (e.g., race and socio-economic status) that were associated with a so-called unhealthy behaviour (e.g., tobacco use) and then sought to change the behaviours of targeted populations (e.g., non-dominant racial and lower-income groups). This experience made me realize that when health is defined so narrowly - in this case as being smoke-free – we neglect to take action on the conditions of people’s lives that affect their health and wellbeing more broadly. A parallel can be drawn with how the issue of weight is addressed. In both Singapore (see Foo et al., 2013) and Canada (see Moor, 2005), clinical and public health interventions aimed at preventing and treating obesity often have a pre-determined goal (i.e. weight loss or management) and seek to modify the specific behavioural and social factors (e.g., a lack of access to nutritious foods) that contribute to the defined problem. I believe that this approach is myopic because it diverts attention away from other issues such as violence, racism,
environmental degradation, and inadequate housing that may have more profound impacts on people’s lives but do not appear to be directly related to the medically defined problem of excess weight.

In my view, social justice starts with an attunement to social injustice and the pressing issues that face others around us; this means getting acquainted with our social reality, including the structures and mechanisms that shape quality of life outcomes, before attempting to initiate change. What I envision as the end goal of social justice is a world in which all individuals have the resources to maximize their capacities and flourish. Within the context of health, I believe that social justice involves understanding individual health behaviours as circumscribed by broader social conditions, and simultaneously recognizing that individuals have situated agency – in other words, agency that is both facilitated and constrained by social structures (Bevir, 2017). As such, I view a social justice approach to health as preserving the fundamental human right for individuals to have self-determination over their own bodies and lives, while understanding self-determination as a fundamentally social process that is engendered by supportive relationships and environments. I distinguish the concept of self-determination from the discourse of individualism, in that the former enables the person to narrate their strengths and their understandings of health, whereas the latter outlines health in advance and then compels the individual to strive towards this narrowly defined ideal. This social justice perspective thus rejects the notion of saving or rescuing marginalized peoples and instead facilitates a safe and welcoming environment where individuals can leverage their strengths to direct their own healing journeys – which may or may not include weight management.

Pursuing this research has been as much about transforming myself as it is about shifting broader attitudes. I acknowledge that even now I grapple with internalized oppression including
fat phobia, and I still display attitudes reflective of healthism, an ideology in which “healthy
behavior has become the paradigm for good living” (Crawford, 1980, p. 380). Through listening
to my participants’ stories, I have learnt to be less judgmental of myself and others when we do
not engage in so-called healthy behaviours or fulfill normative expectations of what it means to
be healthy. As a social justice researcher, I believe that my role in creating social change is two-
fold. First, it is to ask meaningful questions that allow individuals to reflect more deeply on their
lives and their relationships with the world, and the changes that they want to see in these
domains. Second, it is to share my research findings with others, in the hope of contributing to a
broader understanding of health and weight as situated within the intersection of individual and
contextual systems, which will potentially translate into social justice-informed health care.

1.3 The Weight of Language

There have been debates amongst scholars interested in weight-related issues on the
appropriate terms to describe bodies that deviate from weight normative standards (Campbell, 2021). While I use weight stigma as an umbrella term to encompasses bias and discrimination based on body weight, shape, size, and adipose distribution/levels in the body, I highlight that fat phobia, or the revulsion towards adiposity and what it represents, is a specific form of weight stigma given that weight per se does not indicate body fat content and distribution. Fat, in contrast to muscle, has historically been associated with femininity and deemed as an emasculating quality on men in the Western context (Bordo, 2004; McPhail, 2009; Monaghan, 2008). Furthermore, while weight is an objective measure, fat is a more fluid descriptor, and in a “fat phobic society, anyone and everyone might be fat” (Taylor, 2018, p. 461). The dominant biomedical model tends to rely on BMI classifications and uses terms such ‘obesity’ and ‘obese’, reflecting the view that excess weight is a problem to be remedied (Campbell, 2021). On the
other hand, many critical fat/weight scholars have contended that the use of biomedical language pathologizes fat people and reinforces the cultural phenomenon of fat phobia (Burgard et al., 2009; Cooper, 2010). Some of these scholars also highlight how anti-fat discourse is intricately tied to White supremacy and patriarchy, which have historically positioned racially non-dominant and feminized groups as savage, animalistic, and far removed from the self-restraint of White masculinity (Strings, 2019). Thus, reclaiming the stigmatized identity of fat goes beyond body size, and represents a revolution against racism, colonialism, sexism, and other interlocking systems of oppression (Harrison, 2021; Strings, 2019). At the same time, it is important to note that reclaiming language is not a straightforward process. Research indicates that patients often have divergent preferences around weight-related terminology (Volger et al., 2012; Ward et al., 2009). In line with a person-centred approach, during the interview process, I sought to place patients’ perspectives at the forefront by asking them to select descriptors that resonated. In the context of my dissertation, I have decided to use the term ‘larger-bodied’ to capture the collective experiences of patients. I oppose the uncritical use of biomedical language such as obese and overweight, and regard such terms as being imbued with too many negative cultural meanings to be used without inflicting harm. While I strive to be an ally to the fat acceptance movement, I do not myself identify as fat and hence do not use fat as an identity descriptor. Fat remains a politically contentious and emotionally fraught label, as demonstrated by both the existing literature and my participants’ own narratives. Therefore, I contend that individuals should decide for themselves whether or not to take ownership of this politicized self-identification. My use of the term fat makes reference to fleshy matter, as well as participants’ own characterizations of their bodies and identities. When using the term obesity, I denote the
contesting discourses around the phenomenon, which encompass both dominant biomedical and critical fat/weight perspectives.
Chapter 2: Theoretical Framework

In this chapter, I outline a critical realist intersectional framework that enriches the key tenets of intersectionality with the meta-theory of critical realism. I begin by explaining intersectionality, including its strengths and weakness, and then examine how concepts from critical realism can build on intersectionality’s insights. I conclude by discussing how obesity research can be transformed through a transdisciplinary perspective.

2.1 Intersectionality and Social Justice

Intersectionality is an ideal framework for understanding social justice issues such as obesity as it exposes the power imbalances associated with interlocking systems of oppressions (Kelly, 2009). Intersectionality emerged in the late 1980s from growing discontent with the second wave feminist movement, which narrowly focused on the category of gender to understand the social world and individual experience (Hancock, 2007; Hankivsky & Christoffersen, 2008; McCall, 2005). Coined by Crenshaw (1995), who took issue with the invisibility of Black women in both the feminist movement and Civil Rights movement, intersectionality can be seen as a close ally of critical race theory (Bowleg, 2012). Intersectionality draws on critical race theory’s key mandate to “bring race consciousness to the forefront, in contrast to the accepted model of colour-blindness, in an effort to combat the limited understanding of how racism exists within hegemonic power structures in [...] society” (Johnson & Parry, 2015, p. 25). To resist these dominant narratives and change our social reality, critical race theory puts the spotlight on counter-stories, which are stories of those in marginalized positions whose experiences are often not told (Johnson & Parry, 2015). At the same time, intersectionality retains feminism’s core principle of recognizing women and other marginalized groups as the experts on their own experiences, feelings, hopes, and desires (Johnson & Parry,
Intersectionality has since expanded into a broad interdisciplinary approach for examining interlocking inequities such as sizeism, racism, ageism, ableism, sexism, classism, and homophobia (Bowleg, 2012; Martinez et al., 2014). Intersectionality sheds light on the interplay amongst these forms of social oppressions at multiple levels, such as individual experience and identity, social interaction and practices, and institutions and ideologies (Martinez et al., 2014).

A key strength of intersectionality is its understanding of health and illness as situated within multiple social structures; it offers a counter stance to the biologically deterministic view that biomedicine has traditionally taken toward conditions it defines as diseases and illnesses, such as obesity (Hankivsky & Christoffersen, 2008; Kelly, 2009). Biological determinism is the perspective that focuses on how various phenomena are dictated by biological factors, while disregarding or downplaying the role of socio-cultural influences (Warin, 2015). Intersectionality also problematizes the dominant approaches in public health, epidemiology, and biomedicine that regard social differences amongst subjects simply as demographic variables, to be isolated and homogenized in the quest to find direct causal relationships (Hankivsky & Christoffersen, 2008; Kelly, 2009). Instead, intersectionality recognizes that the dimensions of social difference that biomedicine treats as independent variables are socially constructed in time and place, and thus cannot be divorced from the broader context (Rogers & Kelly, 2011).

However, intersectionality, as with certain strands of social and feminist theory, has sometimes focused on social structures and lived experience without engaging more deeply with the ontological issues of life, nature, and matter (Cregan, 2006; Lupton, 2012). This emphasis on the body as metaphorical, discursive, or socially constructed can be understood as a reaction against the ways in which nature has been used as a tool in reductionistic and deterministic ways by the likes of socio-biologists and evolutionary psychologists to justify social inequities.
(Gunnarsson, 2013). As Soper (1995) contends, feminism’s original goal was to dismantle the supposed naturalness of male supremacy and the relegation of women to the domestic sphere, and to uncover how naturalized forces are, in fact, socio-historically constructed and subject to change over time and place. Given that social determinants have historically been overlooked in dominant discourses within science, medicine, and public health, some intersectional perspectives may seek to bring social constructionist understandings of the body to the forefront (Gunnarsson, 2013; Shilling, 2012). While this approach illuminates how interlocking social forces have shaped health inequities and outcomes, it lacks a deeper engagement with the material body and why it matters for social justice (Shilling, 2012).

In my view, a transformative model of intersectionality requires an attention to the intersections not only amongst social phenomena but with biological and physical phenomena as well. Using a primarily social constructionist view to understand bodies downplays the physical challenges that people struggle with, suggesting that such difficulties can be eradicated simply through changing socio-cultural attitudes and policies (Siebers, 2006; Williams, 1999, 2006). Furthermore, denying the explanatory power of biology to subvert biological determinism is a counterproductive strategy because it depends on a deterministic notion of biology: It implies that admitting biology matters for human functioning automatically leads to the conclusion that biology alone determines human behaviour (Gunnarsson, 2013). Radical social constructionism and biological determinism thus share a reductionism that reduces phenomena that are both biological and social to either factor exclusively (Gunnarsson, 2013).

In order to truly overturn biological determinism, intersectionality must offer a more nuanced account of biology by highlighting its pliability and its conditioning role alongside social and environmental factors, without conflating the notion of conditioning with
determinism, which is the idea the phenomena can be completely determined by pre-existing causal factors (Gunnarsson, 2013). To make sense of fat, as well as health and social inequities, intersectionality needs to turn to nature, thereby deepening our understanding of what constitutes the natural limits, needs, and capacities of human beings (Gunnarsson, 2013; Scambler & Scambler, 2013). Challenging an oppressive social order that undermines health and wellbeing requires us to first understand what it is about the nature of human beings that facilitates flourishing under some circumstances and suffering under others (Gunnarsson, 2013). Moreover, without engaging more directly with biology, intersectionality will not be able to destabilize biomedicine’s monopoly on knowledge about the body, health, and obesity science.

2.2 Critical Realism and Social Justice

I have selected critical realism as a complementary framework to intersectionality because of its ability to address the limitations of social constructionist approaches that dominate social justice work (Gunnarsson et al., 2016; Parr, 2015). Coupling critical realism with intersectionality allows us to move beyond both biological and social determinism to appreciate the complexity of health and social inequities. Bhaskar (2008), the founder of critical realism, argues that a fundamental problem with social theory, particularly the two main traditions of positivism and hermeneutics, is the way epistemology (what it means to know) and ontology (what reality is) have been conflated. This so-called “epistemic fallacy” (Bhaskar, 2008, p. 5) assumes that our definition of what is real is based on what we know. Situating itself as an alternative to these traditions, critical realism attempts to disentangle ontology and epistemology, with the main principles of ontological realism, emergence, epistemological relativism, and judgmental rationality.
2.2.1 Critical Realist Ontology

Bhaskar (2008) posits the existence of a reality independent of human action and conception, a view known as “ontological realism” (p. 241). Ontological realism includes corporeal realism - the notion that bodies have their own ontology which is irreducible to the social (Bates; 2015; Shilling, 2005). This ontological view positions reality “as a stratified and differentiated whole whose elements are both intrinsically connected and relatively autonomous from one another” (Gunnarsson, 2017, p. 117). A key component of a stratified reality is the concept of emergence, which suggests that phenomena cannot be attributed to any one part or sum of parts in the system; rather, they come about because of the interaction amongst parts at multiple levels (Yoshizawa, 2012). Emergence is an important conceptual tool for countering reductionism at multiple levels and systems. It highlights how the micro-level of individual agency cannot be reduced to macro-level social structure; biological systems cannot be reduced to social systems and vice versa. From this perspective, a system involves multiple constitutive components mutually shaping one another without losing their distinct identity (Gunnarsson, 2013, 2017; Walby et al., 2012).

2.2.2 Critical Realist Epistemology

In terms of epistemology, critical realism takes a relativistic stance, which acknowledges that our knowledge of the world is subjective, shifting across time and place (Price & Martin, 2018). However, critical realists do not espouse judgmental relativism, or the view that “beliefs are equally valid and there are no rational grounds for preferring one to the other” (Parr, 2015, p. 196). Instead, critical realists subscribe to judgmental rationality, which is the stance that epistemological relativism does not preclude making a rational decision between competing theories to explain phenomena (Sayer, 2012). This does not mean believing in absolute truth, but
rather claiming a truth that can most adequately represent the world at present (Sayer, 2012). This approach rejects the two diametrical poles of objectivity and subjectivity, and sees the process of acquiring knowledge about reality as a continuum (Kaushik & Walsh, 2019).

### 2.2.3 Complexity

Critical realism is enhanced by complexity theory, also known as complex adaptive systems theory, which challenges linear and reductionistic cause-effect models (Walby et al., 2012). A complex adaptive system is defined as a system in which multiple agents are acting in parallel, responding to other agents, and changing one another through mutual adaptation; these collective processes, in turn, shape the whole system (The Health Foundation, 2010; Walby et al., 2012). Complexity theory opens up new ways of conceptualizing healthcare systems and other social systems as a dynamic process involving “patterns, complexity, and interrelationships” (The Health Foundation, 2010, p. 6). Both critical realism and complexity theory share the notion of emergence, which refers to how phenomena within a complex adaptive system emerge in an unplanned manner due to their interactions, developing qualities that cannot be reduced to their individual parts (The Health Foundation, 2010; Walby et al., 2012). Emergence suggests that the whole is not only greater than but qualitatively different from the sum of its individual constituents, given that the properties and powers of the whole cannot be predicted based on the powers and properties of the individual parts (Braithwaite et al., 2018). The related concept of connectivity is key to these perspectives; connectivity suggests that the relationships amongst various agents in a system take precedence over individual agents themselves (The Health Foundation, 2010).

Applying the insights of complexity theory to healthcare management, Burns (2001) has suggested that leaders should direct attention away from prediction and control, towards
cultivating supportive relationships and conditions that enable systems to “evolve to produce creative outcomes” (p. 474). Some central principles of this approach in healthcare management include establishing a “balance [between] data and intuition, planning and acting, safety and risk” (Burns, 2001, p. 480). Likewise, researchers have focused on using complex adaptive systems thinking to guide healthcare delivery (see Capuano et al., 2009; MacKenzie et al., 2008; Mash et al., 2008). Mash et al. (2008) examined how a community health centre implemented changes to improve interprofessional collaboration, incorporating factors such as communication style, team resilience, reflective capacity, and experimentation. The authors concluded that organizational change can be facilitated by changing the goal “from [optimizing] health care delivery in a mechanistic model to [optimizing] health care workers in a living system” (p. 132).

In light of the complexity of the world, one question that remains is how we can identify these unseen and unknown causal powers and mechanisms. Complexity thinkers argue that the answer lies in appropriating a wide range of relevant theories from multiple disciplines to understand the different causal mechanisms at play (Houston, 2001; Martinez et al., 2014). Guided by the notion of complexity, researchers can step beyond their disciplinary silos and collaborate with those in seemingly unrelated disciplines. At the same time, this approach avoids certainty and fixed correlations between variables, which may be unsettling for those accustomed to predictability. It requires us to accept that our investigations are “tentative, probabilistic, cautious and refined over time” (Houston, 2001, p. 853) and yet persist tenaciously towards the larger goal of eradicating social injustice.

2.3 Transforming Obesity Research with a Transdisciplinary Perspective

I believe that obesity should be understood from a transdisciplinary perspective that incorporates both the natural and social sciences, which goes a step further than an
interdisciplinary approach in fostering the mutual crossover and transformation of disciplines (Yoshizawa, 2012). As I have mentioned earlier, a truly intersectional framework requires us to integrate an analysis of multiple axes of power within the social realm with the biological realm. This approach advances an understanding of obesity as a social justice issue where bodies materialize relations and conditions beyond our individual control (Yoshizawa, 2012). Drawing on the example of the Barker hypothesis, I demonstrate how biology can be used to present a more nuanced understanding of the social determinants of health (Yoshizawa, 2012). The Barker hypothesis, named after the foundational work of epidemiologist David Barker, focuses on how processes external to the body are incorporated into the very biology of the body (Warin, 2015; Yoshizawa, 2012). The hypothesis’ basic premise is that a range of diseases, including metabolic disorders, that occur over the life course stem from conditions related to fetal development in the womb (Warin, 2015; Yoshizawa, 2012). In depicting how these conditions are shaped by interactive biological and social processes that evolve over time and place, the Barker hypothesis challenges reductionistic, deterministic, and essentialist notions of biology that pinpoint simple and static cause-effect relationships (Yoshizawa, 2012). For obesity research, this notion of a “diffusive biosocial responsibility that transcends the individual and the present time” (Yoshizawa, 2012, p. 359) suggests that we need to move our lens beyond lifestyle or genetic interventions, towards a biosocial model that incorporates biology, social positionality, place, and generation.

Critical realism supports this movement towards biosocial approaches of understanding obesity and health inequalities. Using critical realism’s key concept of emergence, I position fat, or fleshy matter, as an emergent quality that occurs in an unpredictable ‘open system’, in which multiple mechanisms, both biological and social, interact and modify the effects of fat on the
individual. Fat may be harmful, just as the lack of fat may be harmful, but I believe we cannot draw conclusions on the inherent qualities of fat in a ‘closed system’ with controlled variables. Understanding fat as emergent means that it has properties that cannot be attributed to any one of its constituent parts or the sum of the parts of the system (Gunnarsson, 2013; Warin, 2015). Accordingly, I take the stance that fat, as well as what it represents, is neither primarily a biological fact nor purely socially constructed; it is the materialization of biology, cultural norms, social practices, economic structures, and physical environments (Rice, 2015; Yoshizawa, 2012). This transdisciplinary theoretical framework thus avoids a totalizing explanation of fat where a certain causal factor is overplayed; instead, it allows us to attend to the interactive factors in multiple domains of an individual’s life (Houston, 2001). Guided by this framework, the review of the existing literature in the next chapter will shed light on the complexities and tensions in larger patients’ and practitioners’ perspectives and experiences.
Chapter 3: Literature Review

3.1 Voices of Differently Situated People

To examine the relational dynamics of the clinical encounter, my study showcases both the voices of patients and practitioners. I frame this exploration by reviewing the existing literature on differently situated people within healthcare settings. In ‘voices from above’, I explore the literature on healthcare professionals’ perceptions of larger patients and obesity and the challenges they encounter when caring for larger patients. In ‘voices from below’, I discuss larger patients’ experiences of stigmatization in healthcare settings, the different ways in which they internalize weight stigma, their varying preferences for initiating weight-related discussions, and the ways in which they resist dominant understandings of obesity.

3.2 Voices from Above

Research has been conducted with a range of healthcare practitioners involved in weight-management, including nurses, (e.g., Tanneberger & Ciupitu-Plath, 2018), midwives (e.g., Schmied et al., 2011), dieticians (e.g., Stone & Werner, 2012), and doctors (e.g., Saldaña-Tejeda & Wade, 2018). While a hierarchy exists amongst different clinicians (McDonald et al., 2012), clinicians are often seen to occupy positions of power, because of their expertise, knowledge, and influence (Harris et al., 2008; Lancaster, 2017). Although the powerful remain understudied within the fields of social justice, it is important to include them in research focused on understanding social contexts, processes, and interactions (Charmaz, 2016; Harris et al., 2008). Such research can shed light on how power in healthcare settings is established and maintained, as well as how these power relations shape patients’ experiences (Charmaz, 2016; Harris et al., 2008). Furthermore, research is not simply a means of collecting data but can function as a social
justice intervention by providing an avenue for participants to critically reflect on their unquestioned attitudes, perceptions, behaviours, and practices.

### 3.2.1 Attitudes Towards Obesity

The existing research illustrates that the majority of healthcare professionals displayed individualistic and moralistic attitudes towards fatness, reflecting their belief that larger patients were responsible – either because of faulty genes or lifestyle – for weight gain. Research by Saldaña-Tejeda and Wade (2018) demonstrates practitioners’ continued reliance on the geneticization of race in relation to obesity, and their neglect of broader socio-structural factors that shape weight and health. The authors interviewed nine geneticists and ten doctors treating obese children in Mexico to examine their views on genetics and obesity, particularly in relation to notions of race, class, and national identity. The geneticists were found to draw on the thrifty genotype hypothesis (TGH) to explain the occurrence of obesity amongst Indigenous children. On the other hand, doctors were less likely to use strongly genetically reductionist arguments, but they still connected obesity and Indigenous ancestry – both in terms of biology and culture. Furthermore, when speaking about culture such as food habits, they “often [invoked] epigenetic explanations” (Saldaña-Tejeda & Wade, 2018, p. 2744), such as the expression of genes through behavioural and environmental factors.

Studies with other practitioners, such as midwives (Schmied et al., 2011) and dieticians (Stone & Werner, 2012), indicate that participants focused more on lifestyle factors associated with obesity, and believed that the condition could be fixed through willpower. The majority of participants perceived obesity as unacceptable, and some expressed feelings of repulsion towards their patients. Furthermore, these stigmatic beliefs toward fat involved cognitive, emotional, and behavioural elements (Stone & Wener, 2012). The researchers found that stigma on a cognitive
level included perceptions that larger people were the cause of their weight problems and lacked a willingness to change old habits. On an emotional level, these blaming perceptions often triggered anger and resentment. Behaviourally, such emotions manifested in instrumental avoidance (e.g., shortening the duration of sessions with patients), professional avoidance (e.g., putting in less energy and effort into understanding patients’ issues and implementing a plan tailored to their needs), and interpersonal avoidance (e.g., using a negative tone and body language such as not smiling) (Stone & Werner, 2012).

While individualistic ideologies were prevalent in the healthcare field, research reveals some variances in how different healthcare practitioners understand obesity. Sikorski et al.’s (2013) study with health care professionals, including physicians, nurses, physiotherapists, psychotherapists, and occupational therapists, of a large German university hospital assessed stigmatizing attitudes on the Fat Phobia Scale (FPS) based on a vignette describing a female obese patient. A staggering 99.0% of all participants displayed negative attitudes towards the patient, exemplified through their use of adjectives such as lazy, unattractive, weak, slow, inactive, and self-indulgent to describe her. However, the nursing staff tended to view obesity as an illness (e.g., genetic and metabolic causes) while the physicians were more likely to view obesity as caused by lifestyle (e.g., lack of discipline). Likewise, Petrich’s (2000) study with medical and nursing students found some differences in attitudes between the two groups. While both groups regarded obese individuals as unhealthy and lacking self-discipline, these stigmatizing attitudes were found in 29% more medical students than nursing students, which highlights the need for more research to interrogate the nuances of obesity discourses in the various health disciplines.
3.2.2 Ambivalence and Challenges of Care

Some research suggests that practitioners’ attitudes towards larger patients are often ambivalent rather than wholly negative, and such ambivalence is intimately tied to the physical and psychological challenges of care (Robstad et al., 2018; Shea & Gagnon, 2015). Intensive care unit (ICU) female nurses in Robstad et al.’s (2018) study conveyed that caring for larger patients took a toll both physically and emotionally. While nurses strived to provide empathic care and understand the complexity of obese patients’ conditions, they simultaneously held negative beliefs about patients and found caring for them to be physically demanding. Nurses expressed that obese patients were unkempt, not taking care of themselves, and unwilling to put in effort to make changes. Thus, they regarded obese patients as fundamentally different from themselves. However, some nurses recognized that the demands of caring for obese patients were due to their own negative beliefs, and expressed a desire to counter such beliefs by acquiring more knowledge about the complexity of obesity (Robstad et al., 2018). Shea and Gagnon (2015) similarly found that ICU nurses desired to provide the same quality of care to obese patients as normal weight patients, yet were hindered by their own feelings of disgust, frustration, blame, and anger. Tanneberger and Ciupitu-Plath (2018)’s study with nurses in an acute care clinic in Berlin also indicates that participants grappled with opposing beliefs about obesity and an inner conflict between taking care of their own health and providing the best care for obese patients. Participants expressed that the lack of lifters and special walking frames to support obese patients was taxing on their own physical health (e.g., an increased risk of musculoskeletal damage). They also reported treating larger patients differently because they were disapproving of patients’ habits and bodies, though some participants recognized that their negative bias towards obese patients was due to a lack of understanding and empathy. Moreover,
nurses displayed an awareness that weight bias exists in their profession, though they were more likely to report their co-workers as engaging in such oppressive behaviours, which could be seen as effort to reduce their cognitive dissonance around weight bias (Tanneberger & Ciupitu-Plath, 2018).

Practitioners’ ambivalence also involved navigating between competing discourses from biomedicine and nursing about obesity (Jeffrey & Kitto, 2006). On the one hand, nurses in the study appeared to view obesity from a biomedical lens, and readily quoted the BMI as an instrument for measuring health (Jeffrey & Kitto, 2006). On the other hand, BMI was seen as misaligned with the philosophical underpinning of holism in nursing, which goes beyond biology to understand the psychological and social factors influencing patient health. As one of the nurses in the study expressed: “I don't think [obesity is] related to Body Mass Index at all ... I think [obesity is] when you start to feel uncomfortable with how you perceive yourself...” (Jeffrey & Kitto, 2006, p. 76).

These studies on practitioners’ attitudes towards obesity and the challenges of care underscore the pressing need to change the structural conditions of healthcare to accommodate larger patients, as well as cultivate in clinicians a more nuanced understanding of weight. One limitation of the studies reviewed was the lack of an intersectional analysis of healthcare professionals’ attitudes and behaviours. Some of the studies reviewed did not provide any demographic information about participants, while the studies that typically listed social characteristics such as gender and age, made no mention of race. Furthermore, none of the studies reviewed above examined the significance of these social categories on health professionals’ behaviours and attitudes. This gap reflects how dominant approaches in public health, epidemiology, and biomedicine continue to treat social differences simply as
demographic variables, rather than meaningful constructs infused with power and privilege (Hankivsky & Christoffersen, 2008; Kelly, 2009).

3.3 Voices from Below

The literature on weight-based oppression experienced by larger patients within healthcare has typically focused on their interactions with doctors (e.g., Bombak et al., 2016; Chugh et al., 2013; Drury & Louis, 2002), though experiences with other healthcare professionals such as physiotherapists (e.g., Setchell et al., 2015) and nurses (e.g., Creel & Tillman, 2011) have also been examined. The transformative power of examining marginalized communities lies in exposing their lived experiences, challenging hegemonic forms of knowledge, and centering their voices in the generation of new knowledge. Research shows that larger patients reflexively engage with dominant obesity discourse, negotiating personal definitions of health and size in tandem with other social categories they identify with (Meleo-Erwin, 2012; Williams, 2017). Such research can shed light on discursive tensions and ambivalent embodiments, where individuals grapple with pressures to take individual responsibility for weight control while resisting normative messaging (Bombak & Monaghan, 2017).

3.3.1 Healthcare as Stigmatizing

The studies reviewed indicate that many larger patients experienced humiliating encounters with health professionals in which they were judged negatively because of their weight. These stigmatizing attitudes occurred in both overt and covert ways, and the line between them was often blurry (Bombak et al., 2016). Bombak et al.’s (2016) study on larger women undergoing fertility care exemplifies this convergence between covert and overt stigma. Participants described how physicians outrightly denied them basic screening, expressed disgust,
and engaged in name-calling. In one example of a more extreme use of insensitive language, a participant was told by a physician that “if you don't get that weight off you now, you're going to be a menace to the government” (p. 98). Participants also recounted how stigma manifested more covertly, in that they were made to feel like they would be inadequate mothers who put their fetuses at risk due to their weight (Bombak et al., 2016). A range of stigmatizing behaviours was also apparent in Setchell et al. (2015)’s study on physiotherapy patients, who reported that their physiotherapists believed that obesity was self-inflicted and displayed little sensitivity to the issue of weight stigma. Participants also encountered stigma in more insidious ways when their physiotherapists unnecessarily emphasized weight. That said, a minority of participants described positive experiences of negotiating weight with physiotherapists. One participant noted that the physiotherapist brought up weight in an appropriate way by explaining that “[losing] weight would help but the main thing was to strengthen the quadricep muscle” (p. 838). The research thus demonstrates the need for clinicians to convey information to patients respectfully and sensitively, rather than completely shun discussions about weight (Bombak et al., 2016; Setchell et al., 2015).

3.3.2 The Intersection of Weight Stigma and Other Social Identities

The bulk of mainstream weight stigma research lacks an intersectional analysis, focusing primarily on young, White, middle-class women in Western populations (Nolan & Eshleman, 2016). This combined identity has been depicted as upholding significantly thinner beauty ideals and displaying a greater preoccupation with dieting and weight in comparison to other groups (Nolan & Eshleman, 2016; Powell & Kahn, 1995). The narrow focus on this particular demographic, however, does not account for how diverse groups experience the effects of having bodies that deviate from Eurocentric, patriarchal, ageist, and classist standards of beauty and
health. A smaller body of literature has sought to analyze fat embodiments and oppression in conjunction with the construct of race, primarily examining Black women in the United States. Chugh et al. (2013) conducted interviews with White and Black women to examine and compare their perspectives on their primary care physician’s role in weight loss counselling. The authors found that White women were more likely to express feelings of depression surrounding their weight whereas Black women were more likely to express positive body image. Similarly, other research in the United States suggests that although larger Black women are discriminated against for race and size, they experience greater body acceptance (Lovejoy, 2001; Williams, 2017), “less compulsion to manage their bodies’ nonconformity” (Kwan, 2010, p. 155), and lower levels of disordered eating (Shuttlesworth & Zotter, 2011) because of differing constructions of feminine beauty in Black communities. These patterns appear to be consistent for Black women across lower to middle class groups, though future research on diverse populations is necessary to shed more light on how class intersects with other social identities to shape embodied experiences (Kwan, 2010). It has been proposed that individuals who positively identify with a stigmatized category may experience a protective effect on their self-esteem (Nolan & Eshleman, 2016). Several protective factors against internalized fat phobia for Black women include having a less rigid body ideal, supportive family environments that enhance independence and self-esteem, and strong peer support celebrating distinctive and less conformist aesthetics (Kwan, 2010; Lovejoy, 2001; Rubin et al., 2003).

However, it is important not to overstate racialized women’s disregard for norms in a society that enshrines thinness. As Black fat studies scholar Daufin (2020) contends, “Black [women] don’t get some kind of ‘Get-Out-of-Weight-Stigma-Free’ card” (p. 160). Drawing on her research and personal experiences in an applied autoethnographic study, Daufin (2020)
suggests that while Black women may not aspire for the exact thin ideals as White women, they nevertheless pursue goals related to weight loss and weight management. She argues that Black women’s higher weight goals (e.g., a size 8 rather than a size 2) are reflective of Black women’s overall higher weight status rather than a disregard for thinness; as such, researchers should be careful not to conclude that Black women enjoy more positive body image and higher self-esteem. Furthermore, Daufin (2020) contends that Black women may face challenges with expressing their experiences around weight stigma because of the notion that “issues of fat acceptance and sizeism are narrow, apolitical concerns that diminish the more important concern of racism” (p. 167).

Another area of focus has been on how weight stigma is shaped by cultural factors, such as immigration and acculturation status. Acculturation refers to a process in which an individual adapts to the traits of a culture that is not originally their own (Wu et al., 2020). In Rodrigues’ (2017) review of the literature, it was found that Hispanic girls and women who have adapted to American cultural norms that valorize thinness experience a shift in their body size preferences and a greater risk for disordered eating patterns. However, findings from another study suggest that acculturation status did not predict levels of bodily dissatisfaction and unhealthy behaviours amongst Latinx, Hmong, and Somali adolescents (Eisenberg et al., 2019). The researchers speculate that due to globalized media, individuals located in various parts of the world may already have been exposed to and adopted Western body ideals within their heritage cultural communities (Eisenberg et al., 2019). Furthermore, it is important to note that the idealization of thinness is not exclusive to Western cultures. In Wu et al.’s (2020) study on Asian Americans, most of whom were first generation Chinese-speaking immigrants, the majority of participants experienced weight stigma even though their BMI was under 27.5, which may not be perceived
by others as being of a larger size. The authors suggested that participants may still encounter body shaming from family members who live in Asia, where lower BMI cut-off points for obesity and overweight are used, in turn influencing body size preferences.

Other research has explored how the cultural preoccupation with body size intersects with masculinity and sexual identity. The pursuit of the idealized male body often “involves striking a balance between both thinness and muscularity” (Foster-Gimbel & Engeln, 2016, p. 6). At the same time, the preoccupation with dieting and slenderness is often viewed as a normatively feminine practice, which can pose a threat to masculine identity (Temple Newhook et al., 2015). In a study with men and women who underwent weight loss surgery, male participants who spoke about their experiences with the surgery appeared to grapple with hegemonic norms of masculinity that discourage emotional vulnerability and concern for physical appearances (Temple Newhook et al., 2015). Men also shied away from the feminized label of fat, choosing instead to describe themselves as a “big guy” (Temple Newhook et al., 2015, p. 657). Unlike the women in the study, male participants more readily “[drew] on a discourse of a big male body as tough, robust, and strong” (Temple Newhook et al., 2015, p. 658). These masculine norms converge with sexuality, and research on men with non-dominant sexual identities, including gay and bisexual men, has highlighted the increased prevalence of internalized weight stigma amongst this population relative to heterosexual men (Austen et al., 2020; Austen & Griffiths, 2022; Puhl et al., 2019). Compared to heterosexual men, gay men have been found to hold more anti-fat attitudes, directed at both themselves and potential romantic partners (Foster-Gimbel & Engeln, 2016). This vulnerability to internalized weight stigma has, in part, been attributed to the oppressive and misogynist beauty ideals in gay male culture that emphasize very low body fat and high muscularity, as evident in the popularized expression of ‘no fats, no femmes’ (Austen &
Griffiths, 2022). Gay men also show similar levels of bodily dissatisfaction as heterosexual women (Engeln-Maddox et al., 2011), which has been linked with how both groups experience pressure to pander to the male gaze (Legenbauer et al., 2009). Austen and Griffiths’ (2022) research with sexual minority men found that internalized weight bias predicted reduced psychological wellbeing and future weight gain. Moreover, weight stigma was internalized not solely through encounters with more overt forms of discrimination but also from “the passive everyday experiences of living in a world where fatness is devalued” (Austen & Griffiths, 2022, p. 9). Taken together, these findings indicate that an intersectional analysis must consider the ways weight stigma plays out differently, but not less significantly, in the lives of multiply marginalized groups immersed within interlocking systems of oppression and domination (Daufin, 2020).

### 3.3.3 Patients’ Preferences in Weight-Related Discussions

Within the literature on weight stigma, some research has focused on patients’ preferences surrounding discussions of weight. Not all of these studies position discussions of weight as inherently stigmatizing, and instead demonstrate how interpersonal factors influence whether patients perceive such discussions as degrading or empowering. Chugh et al. (2013)’s study found that despite differences in how Black and White women in a weight loss program internalized weight stigma, both groups desired a similar approach to weight loss counselling, which included practitioners 1) providing individualized weight loss advice, 2) discussing weight in a respectful manner, and 3) encouraging weight loss efforts. Most participants wanted their doctors to be more involved and conveyed that they would have been more motivated to lose weight if their doctors had brought up weight loss and set goals for them. Some participants noted that doctors who affirmed small weight losses spurred them on to lose further weight.
Similarly, larger patients in Malterud and Ulriksen’s study (2010) expressed a desire for weight to be brought up by their General Practitioners (GPs) – if it was done with sensitivity and consideration. Some participants admitted that their reluctance to discuss weight was driven by feelings of embarrassment rather than a lack of interest in weight management. Nevertheless, patients stressed the importance of GPs paying attention to their other health concerns, rather than immediately attributing any concern they raised to being overweight (Malterud & Ulriksen, 2010).

While the studies reviewed adopt an ethical stance against weight stigma, it is important to note that their research designs are rooted in the assumption that obesity is a serious health problem warranting intervention. These philosophical underpinnings may have influenced the researchers’ recruitment strategies, encouraging them to target patients who desired weight loss, who had voluntarily enrolled in weight management programs, and/or who were more comfortable with discussions around weight. Such studies used BMI as an eligibility criterion for participation, which may have alienated participants who rejected this measurement tool. Therefore, some findings about patient preferences may not apply to individuals without similar weight loss goals.

3.3.4 Resisting Dominant Anti-Obesity Discourse

Some research has challenged the dominant assumption that larger people should have the ability – or desire - to lose weight simply through practicing self-control. Puhl et al.’s (2008b) study was the first to ask overweight and obese individuals (as defined by BMI) about their recommendations for potential strategies to reduce weight stigmatization and bias. While the study framed obesity as a serious health problem by default, the findings shed light on the misconceptions about larger people. The top suggestion from participants (274 females and 44
males) was increasing education, particularly around the complex causes of obesity, the challenges of weight loss, and the myths of larger people being lazy or greedy. The second most commonly cited suggestion was to increase empathy, sensitivity, and weight tolerance towards obese individuals. More than one-third of the participants highlighted that they were unable to manage their weight despite multiple and ongoing attempts to do so. Many participants also stressed that obesity was a multifaceted condition, that food could be highly addictive, and that they should not be personally blamed for their weight issues.

Research shows that self-blaming emotions continue to be common amongst many larger individuals, reflecting the powerful discourse of taking personal responsibility for health (Kirk et al., 2014; Pausé, 2014). Self-blame can, however, co-exist with self-awareness, as larger individuals were often acutely aware of the complexities of trying to regulate their bodies, acknowledging various cultural, social, and organizational barriers and influences (Kirk et al., 2014; Pausé, 2014). Building on the counter-discourse of fat acceptance that has emerged alongside the war on obesity, research with larger people showcases oppositional fat identities that disrupt popular assumptions about fat – and go a step further in allowing pleasure to be found in inhabiting larger bodies (Meleo-Erwin, 2012). Pausé (2014), who explicitly identifies as a fat studies scholar, presented a collection of stories featuring the experiences of fat women navigating healthcare. While many of the participants subscribed to dominant disease model of obesity, a small minority subverted the narrative that fat was necessarily pathological and regarded the war against obesity as a war against fat people (Pausé, 2014). Likewise, Shahed et al.’s (2022) study, which compared patients’ and General Practitioners’ perspectives on obesity, found that a handful of patients expressed that obesity did not impact their quality of life and that they did not need treatment. The researchers highlighted the stark contrast between this patient
perspective and General Practitioners’ perspectives, which included seeing obesity as a lifestyle problem, hereditary, and/or an eating disorder (Shahed et al., 2022).

Given the pervasive weight stigma in healthcare settings, many patients felt compelled to advocate for themselves to receive better care. LaMarre et al. (2020) explored the healthcare experiences of women and trans men diagnosed as ‘overweight’ or ‘obese’ who were pregnant or seeking to become pregnant. Participants expressed that they had to challenge assumptions about their bodies and navigate material barriers to accessing care. While self-advocacy sometimes resulted in better care, participants highlighted that they should not be required to engage in this level of self-advocacy. Rather, what was needed was a shift towards more inclusive healthcare spaces that were accepting of differences around weight and other intersecting identities (LaMarre et al., 2020). For example, participants wanted practitioners to ask them about their health behaviours without making reference to their body weight (LaMarre et al., 2020). Other studies reveal that in the face of a hostile healthcare environment, the onus often falls on larger patients to assert their needs and preferences. Merrill and Grassley’s (2008) study indicated that some participants, despite not receiving initial support from their healthcare practitioners, persisted with finding alternative practitioners who could provide quality care. Similarly, Buxton and Snethen (2013) found that patients prided themselves on being able to stand up for themselves in their interactions with their healthcare providers. While these narratives of resistance present an important counter narrative to anti-fat rhetoric, there remains a dearth of research that explores larger patients’ positive encounters with healthcare practitioners, particularly practitioners who are social justice oriented. Such research is critical to “[move] the responsibility away from the receiver of care to the provider” (LaMarre et al., 2020, p. 358). Exploring the relational dynamic between providers and patients would shed more light on how
social justice-informed care can transform the patient experience. However, the majority of the literature reviewed tends to focus on either patients or practitioners, with only a handful of studies concurrently exploring both perspectives (see Malatzky & Glenister, 2019; Shahed et al., 2022). Furthermore, most of the weight stigma research has been conducted in the United States (see Papadopoulos, & Brennan, 2015; Spahlholz et al., 2016; Wu & Berry, 2018 for systematic reviews of weight stigma research), with relatively less attention on the Canadian context. This is a significant gap in the literature given Canada’s publicly funded healthcare system, and its underlying value of healthcare as a shared responsibility, which potentially offers a pathway of resistance against the dominant Western ideology of individualism (Donnelly & McKellin, 2007).

In summary, the studies reviewed above demonstrate that obesity is a contested, complex, and stigmatized condition. Healthcare practitioners have been found to display stigmatizing and ambivalent attitudes towards larger patients and experience caring for larger patients as challenging, in part because of organizational and systemic factors beyond practitioners’ control. In turn, larger patients who are subjected to weight discrimination often experience feelings of shame and powerlessness, though they may internalize weight stigma differently depending on their other social positions, such as race, gender, and sexual orientation. Although I have drawn on the categories of voices from above and below to frame these findings, I acknowledge that individuals do not fit neatly into such binaries, and are simultaneously enabled and constrained by social forces. Lancaster’s (2017) study with elite participants, including clinicians, policy makers, advocates, and researchers, illustrates that power, as well as the accompanying concepts of sensitivity and vulnerability, are fluid, relational, and context-dependent, rather than static and inherent. Accordingly, even though healthcare practitioners may have relational power within the
practitioner-patient dynamic, they may still experience vulnerability within larger structures (Lancaster, 2017). For example, asking healthcare professionals to describe discriminatory practices in the workplace “potentially [exposes] them to retaliation, […] job loss, [and damaged] relationships” (Lancaster, 2017, p. 98). By featuring both the perspectives of healthcare practitioners who espouse a commitment to social justice and larger patients whom they work with, my study considers the broader field of power that participants operate in, and the multiple social positions they hold within and beyond the healthcare interaction.
Chapter 4: Methodology

In this chapter, I outline a critical realist intersectional methodology premised on the notion of a complex and multi-layered reality. Drawing on the epistemological and ontological assumptions of critical realism, I focus on interviews as a specific method for investigating this reality. I discuss my sampling frame, data collection, and data analysis, and then consider ethical issues such as research compensation, informed consent, and privacy. I conclude the chapter by exploring some of the key challenges involved in conducting the study.

4.1 Critical Realist Intersectional Methodology

Critical realist intersectional methodology values the subjective knowledge of participants in a specific context, alongside the existence of mind-independent structures that both constrain and enable participants (Flatschant, 2016). I use hermeneutically-based methodologies as the starting point to provide a glimpse into the interior of my participants’ social life (Bhaskar, 2016). Amongst the hermeneutic approaches, I narrow my focus to the interview, which is my primary method of data collection. The purpose of an interview is to “create a conversation that invites the participant(s) to tell stories, accounts, reports and/or descriptions about their perspectives, insights, experiences, feelings, emotions and/or behaviours in relation to the research question(s)” (Smith & Sparkes, 2016, p. 103). The interview context is seen as a safe space that allows for rapport-building and the exchange of intimate information that participants may be less comfortable disclosing in a group setting (Baxter & Babbie, 2003).

In the literature on interviews, there are disagreements about the most appropriate way to conduct interviews, which reflect the different philosophical underpinnings of the main approaches - positivism and hermeneutics (Smith & Elger, 2014). The interview appeals because it seemingly grants the researcher direct access into the participants’ accounts of lived experience...
(Smith & Elger, 2014). Within the social sciences, positivists have generally sought to control bias by ensuring that all questions are standardized and posed by value-neutral interviewers (Smith & Elger, 2014). Positivism is, however, limited because of its disregard for unobservable phenomena and its lack of attention to the social, contextual, interpersonal, and intrapersonal factors contributing to phenomena (Oladele et al., 2013). Conversely, the hermeneutic tradition, which is based on constructivism, seeks to write individual subjectivities back into the picture (Martinez et al., 2014). Hermeneutically-based researchers embrace the possibility of joint knowledge construction, regarding the interview as a platform in which emotions and experiences are explored by the researcher and interviewer in tandem, leading to new meanings (Smith & Sparkes, 2016). The most radical forms of constructivism elevate subjective experience, along with narratives and representations, in determining reality, and do not engage with the scientific evidence base of biological mechanisms contributing to health outcomes (Williams, 1999). Such approaches are fundamentally in conflict with biomedical and public health approaches that seek to intervene on biological phenomena possessing a reality beyond individuals’ perceptions (Williams, 1999). These health disciplines take a realist stance that medical conditions exist and operate independently of consciousness, and may sometimes be able to be “objectively modified” (Clark et al., 2007, p. 519) through healthcare interventions. Critical realist intersectionality challenges positivism’s value-neutrality towards interviews, yet diverges from strands of constructionism that consider interviewees’ accounts as reflective of reality in their own right (Smith & Elger, 2014). Instead, it emphasizes that interviews function as bounded spaces that form just one layer of reality (Smith & Elger, 2014). Importantly, critical realist intersectionality requires the researcher to adopt a non-relativist understanding of social relations, and critically assess “rival narratives” (Smith & Elger, 2014, p. 114) about social
reality. This approach uses judgmental rationality, or the stance that different truth claims can be evaluated as being better or worse, to identify findings that most closely approximate the truth (Brannan et al., 2017; Flatschart, 2016). Judgmental rationality is contrasted with the kind of judgmental relativism espoused by Smith and Sparkes (2016), in which all beliefs are deemed to have equal truth value and the truth is seen to be performative and an “achievement on the part of social actors” (p. 122). From a critical realist perspective, interviewees’ accounts cannot be seen as “a series of discrete but equivalent narratives” (Smith & Elger, 2014, p. 120). For example, a healthcare professional may claim to adopt a social justice approach towards treating patients, but the patient may not feel that their concerns are being heard and instead experience the clinical interaction as unpleasant or oppressive. Furthermore, given that certain “structures and processes […] are only partially understood by those involved” (Smith & Elger, 2014, p. 114), the researcher will need to retain their critical analytical faculties, tenaciously asking challenging questions to move beyond “initial resistance or vagueness” (Smith & Elger, 2014, p. 115). I acknowledge that this notion of scrutinizing participants’ accounts can be challenging to reconcile with a social justice sensibility that seeks to position participants as experts on their own lives. Parr (2015), a critical realist feminist, reflects on her efforts to resolve this tension between judgmental rationality and her desire to value women’s stories. In her data analysis, she began with women’s perspectives and listened to the significance they placed on certain events in their life. However, Parr (2015) concedes that she selected extracts from the interview transcripts that appeared most pertinent to answering her research questions, noting that some respondents were featured more than others because they had more relevant information to share. Further, she did not always accept her participants’ accounts as straightforward evidence and instead drew upon sociological theories to “reconstitute the women’s experiences” (Parr, 2015,
Likewise, Skeggs’ (1997) study on working class women found that her participants disavowed the notion of class as an influence on their lives. However, instead of taking their accounts at face value, she maintained her own interpretation of “the centrality of class” (p. 203) in their lives based on her socio-historical knowledge. Judgmental rationality thus requires the researcher to maintain some degree of control over the interview process and the research agenda. As Parr (2015) acknowledges, she ultimately had the “final say in deciding what participants’ experiences revealed and [her] research findings represented [her], not [her] respondents’, interpretations” (p. 202). In line with critical realist feminists (see Parr, 2015; Satsangi, 2013), I contend that social justice research should strike a balance between demonstrating respect and empathy for participants’ experiences, and maintaining a position that a material reality exists – and therefore, that certain truths count more than others. Of course, there is no precise way in which I can assess whether the right balance has been achieved. I can, however, allow my interpretation of reality to be equally subject to judgmental rationality. I have used quotations from my participants that describe their experiences to allow my readers to assess how reliable my interpretations are (Robstad et al., 2018). I make no claims to epistemic certitude and encourage my readers to uncover my values, biases, and assumptions. After all, it is through maintaining our critical curiosity and generating new ideas and knowledge that we collectively open up possibilities for social change.

4.2 Data Collection

I conducted in-depth, semi-structured interviews with a total of 42 Canadian participants - 22 healthcare practitioners and 20 patients of the same practitioners. The average duration of each interview with practitioners was 60 minutes and 57 minutes for patients. All interviews were conducted over the phone or Zoom, with some follow up correspondence over email,
allowing participants from different provinces across Canada to be recruited. Practitioners and patients were posed a list of questions (see Appendices A and B for the interview guide) including their definitions of social justice in practice, their preferred terms for discussing weight, and their views on socio-cultural factors (with reference to a list of different socio-cultural factors indicated in Appendix C) that influenced health and social identities.

Practitioners were also asked about their stances on discussing weight management with patients, and patients were asked about how, if at all, they felt their weight affected their health, and their weight-related experiences in the patient-practitioner dynamic. Given the dynamic nature of semi-structured interviews, follow-up and clarifying questions were tailored to what participants initially disclosed and emphasized during the discussion.

I used a combination of methods for recruitment, beginning with purposive sampling of practitioners. Purposive sampling “[recognizes] that some informants are better situated to provide key insight and understanding than others” (Abrams, 2010, p. 537). As such, this approach involves selecting participants who can best serve research objectives (Patton, 2002).

Firstly, using online search engines, I generated a preliminary list of healthcare professionals in Canada who self-identified as advocates of social justice, weight-inclusive, intuitive eating and/or HAES approaches in their public profiles. I did not screen practitioners based on any predetermined criteria of social justice as my intention was to examine the nuances in how practitioners conceptualized social justice, as well as how they translated these varied understandings into practice. I also targeted academic clinicians who have been found to be more likely to participate given their stronger commitment to the value of research (Asch et al., 2000).

All shortlisted practitioners were contacted by me through personalized emails (refer to Appendix G) which included an information sheet on my study (refer to Appendix F). This
approach aligns with Signorelli et al.’s (2018) findings that the most effective method of scheduling interviews appeared to be email and that personalization of emails positively influenced participation through helping to establish a stronger connection between the participant and researcher, and increasing the research project’s value. Given that my study adopts an intersectional lens and explores interlocking social inequities beyond weight stigma, I wanted to ensure that practitioners would be comfortable engaging with such issues. Practitioners were provided with sample interview questions exploring social justice in healthcare practice to determine if they would be a good fit for the study. Those who confirmed over email correspondence that they would be able to speak to social justice practices and had experiences interacting with larger patients were then included in the study. Secondly, I adopted the healthcare practitioner liaison approach, which relies on personal contact from a healthcare practitioner to recruit fellow practitioners (Asch et al., 2000). One of my doctoral committee members, Dr. Robert Woollard, who is an influential physician-activist, assisted me with recruitment by sending a personalized email (see Appendix H) to social justice-oriented practitioners in his social network. Thirdly, I employed snowball sampling, requesting the healthcare practitioners I had identified to refer other relevant practitioners. To examine the intersections amongst the lived experiences of weight stigma and socially significant categories, particularly race, gender, and class, where possible, I targeted clinicians of colour and those whose profiles indicated that they worked in community-based settings, which were more likely to serve diverse communities. After selecting practitioners, I sought their assistance with posting flyers at their clinics and/or sending out e-flyers (refer to Appendix E) to patient electronic mailing lists. Given that practitioners can be protective of their patients (Asch et al., 2000), I explained to the practitioners the significance of featuring the patient voice as part of a social
justice framework and the measures I would take to minimize risks of harm to patients. The flyers provided an overview of my study and invited patients who self-identified as fat, large, overweight, or living with obesity to contact me. This approach corresponds with critical fat/weight studies which avoids using participants’ BMI or other physical measurements as inclusion criteria and instead emphasizes patient self-definition (Bombak et al., 2016). All 20 participating patients were recruited from 6 out of the 22 practitioners in the study; the remaining practitioners were unable to recruit their patients either because of recruitment restrictions or a lack of patient interest. Patients were visiting practitioners for a range of reasons including weight management, coping with weight stigma, lifestyle modification, and/or for general medical appointments.

The study was approved by the UBC ethics review board, and all participants provided informed consent (Appendices I and J) electronically through the UBC-hosted Qualtrics site. Participants also filled in their demographic information in a short online survey (Appendix D) on Qualtrics when they submitted their consent forms. The breakdown of participants’ demographics by profession, gender, and race, which were the focus of the data analysis, is represented in Figure 1 below. The majority of the practitioners were Registered Dieticians (RD), female, White, and practicing in either Ontario or British Columbia. The majority of the patients were female and White, and were seen by Medical Doctors (MD). On average, patients were in a lower income bracket and had less advanced educational degrees relative to practitioners.

**Figure 1**
4.3 Data Analysis

Upon completing the data collection, I employed critical thematic analysis (Lawless & Chen, 2019) to examine the interview material. Critical thematic analysis is informed by an explicit commitment to social justice and seeks to identify themes of power relations and hierarchies, as well as historical, social, economic, and political contexts in the data (Lawless & Chen, 2019). Such an analysis not only challenges dominant structures but envisions spaces where resistance and change are possible (Lawless & Chen, 2019). Critical thematic analysis is compatible with an intersectional critical realist approach as it can be used to examine different perspectives on reality while recognizing the fallibility of such perspectives (Bonnington & Rose, 2014).

I drew upon Smith and Elger’s (2014) critical realist approach to making sense of data which is pluralistic and subverts the binary of purely deductive or inductive approaches. Nevertheless, this approach is explicitly theory-led and therefore begins deductively. As with Gilgun (2013), I believe that the initial phase of research requires a deductive approach given that “researchers do not begin as blank slates […]” (p. 112). Rather, it is the researcher’s “prior knowledge, sensitizing concepts, conceptual frameworks, or cognitive schemas” (Gilgun, 2013,
p. 112) that orient them to attend to particular phenomena and overlook others. Bowleg (2017) similarly highlights the shortcomings of the blank slate approach which “often manifests in the language of ‘themes that emerged’ as if the themes were there all along just waiting to be discovered” (p. 680). While I began with theory, I simultaneously concede to theory’s tentative nature (Smith & Elger, 2014). This involves being cautious not to “overstate the clarity of the conceptual framework deployed […] nor underplay the challenges involved in moving between that framework and informants’ accounts” (Smith & Elger, 2014, p. 118). Drawing on my literature review, theoretical framework, and research questions, I listed core elements of social justice practice such as person-centred care, critical consciousness, structural competency, and inter-professional collaboration, which served as guide for understanding the interview data. I then developed preliminary themes, applied them to a few transcripts, and assigned codes to their corresponding themes. Through this process, the original themes and codes were refined, combined, and re-organized. Using the established comprehensive code manual, the process was repeated with both the initial and remaining transcripts. At the same time, an inductive approach was undertaken by examining the repetition, recurrence, and forcefulness of themes (Owen, 1984) that were not captured in the initial coding scheme but were nevertheless linked to the broader thematic categories. I was mindful that participants may offer new and alternative perspectives on social justice in practice. Thus, during the coding process, I began with themes I identified, but also considered “issues raised by the respondents themselves” (Ritchie & Spencer, 1994, p. 180). Some inductive codes included practitioners self-disclosing and finding common ground with patients, and patients perceiving practitioners’ thin privilege to be a barrier. During this iterative process, corresponding codes were listed under each theme as the transcripts were
reviewed, with the themes and codes then refined, combined, and/or subsumed under one another in the codebook (see Appendix K).

When deciding on the final selection of codes and themes to feature, I incorporated both quantitative and qualitative analytical approaches. I counted the number of times that certain codes appeared in relation to others, which aligns with a critical realist approach that attempts to get closer to the material reality; numbers do often matter in capturing what is significant in people's lives. At the same time, numbers alone did not determine whose stories I brought to the forefront. Certain codes illuminated power relations and social structures, and I chose to feature these codes even if they only appeared a couple of times e.g., the dangers of excessive practitioner self-disclosure, as noted by a few patients. Data analysis is ultimately both an art and science, and I acknowledge that as a researcher, I had the power to choose what kind of story I wanted to tell.

4.4 Ethical Considerations

Social justice research is underpinned by ethics which are the “rudiments of what is right and what is wrong” (Johnson & Parry, 2015, p. 54), while recognizing that right and wrong can exist on a spectrum rather than a dichotomous scale. This perspective aligns with the critical realist concept of moral realism, which is a normative judgment about social reality (Sayer, 2012). Social justice research necessitates moral realism as researchers cannot initiate change without first developing a set of values about what needs to be changed (what is wrong) and what our vision of change is (what is right). Informed consent and transparency are two integral and interconnected aspects of what constitutes ethical behavior in social justice research (Cheraghi et al., 2014; Johnson & Parry, 2015). Transparency refers to elements such as disclosing to participants that they are being studied, the goals of the study, as well as the risks
and benefits of participating in the study (Johnson & Parry, 2015). After such information has been conveyed, researchers can obtain from participants their informed consent or a voluntary agreement to participate (Johnson & Parry, 2015). Obtaining informed consent is of particular importance when studying marginalized groups to prevent exploitation (Johnson & Parry, 2015). Prior to obtaining consent (Appendices I and J), I provided an information sheet explaining my study’s goals (Appendices E and F) to give participants time to reflect and ask any clarifying questions. I also gave the participants a chance to opt out of answering certain questions or quit the study if they experienced discomfort with any information at any point in the interview process. I recognize that the interview process always involves an element of uncertainty - the interviewees will be guided through a process of reflection that may generate new insights about themselves that they did not know or were not fully aware of beforehand (Patton, 2002). Given that the interview may delve into areas that the participants did not expect from the outset, I adopted a model of process consent, in which consent is re-affirmed throughout the entire research process (Byrne, 2001; Hoeyer et al., 2005; Nunkoosing, 2005).

Respect for participants’ privacy is another ethical consideration (Cheraghi et al., 2014). However, as Patton (2002) notes, the dominant assumption of privacy is “being challenged […] by participants in research who insist on owning their own stories” (p. 278). Participants who engage in activism and adopt strong political stances are more likely to take pride their identities (Patton, 2002). However, I did not offer participants the option of retaining their full identities on the report given that any participant who reveals their identifying information may risk undermining the confidentiality of other participants based at the same clinic. I have removed all identifying details in my findings and given participants numerical identifiers to protect their confidentiality.
An additional ethical issue I considered was research compensation, which, particularly for structurally marginalized populations, remains a contentious practice (Collins et al., 2017; Dickert & Grady, 1999; Pandya & Desai, 2013). Since research ethics boards recognize that compensation incentivizes participation, they have raised concerns that participants may engage in research solely for financial need, while disregarding the risks of research (Dickert & Grady, 1999). Thus, research compensation is seen as potentially increasing the vulnerability of already marginalized populations (Collins et al., 2017). While I agree that consideration should be given to concerns of increasing participants’ vulnerability, I see the solution not as minimizing compensation but minimizing risks of harm, which I have strived to do through the informed consent process outlined earlier. Prior research has demonstrated the need for “compensation protocols […] to be […] attuned to [participants’] lived realities” (Collins et al., 2017, p. 12). To investigate the ethical implications of research compensation, Collins et al. (2017) conducted focus groups with people living with HIV who use drugs. Participants’ accounts underscored the misalignment between “altruistic expectations of research participation and their real material needs” (Collins et al., 2017, p. 6). Participants viewed research as a transactional process and were not driven to participate because of interest in a research topic, even if they were open to learning about findings (Collins et al., 2017). As one participant noted, “we’re giving you something right, so we just feel [that compensation is] fair” (Collins et al., 2017, p. 6). This view of research as transactional gave participants the opportunity to shift the researcher-participant power dynamic towards fulfilling their material and monetary needs (Collins et al., 2017). In line with such findings, I have used my research as a platform to recognize and validate the historically subjugated knowledge of marginalized groups. I provided $50 to each patient as remuneration for participation, which is particularly timely given that the COVID-19 economic
downturn has disproportionately affected marginalized groups (Cooper, 2021). Participants’ demographic information indicated that patients were, on average, in a lower income bracket relative to practitioners. I did not provide incentives to healthcare practitioners given that an extensive review of studies on the recruitment of practitioners demonstrates that incentives have minimal impact on participation rates (Asch et al., 2000). Asch et al.’s (2000) own experience suggests that even incentives of up to $250 do not necessarily increase participation, though a number of participants expressed that substantial incentives were helpful.

4.5 Challenges

The key challenges I encountered in the research process pertained to recruitment. I sought to recruit a wide range of practitioners, but was only able to recruit physicians, dieticians, and mental health professionals. Most of the online resources for weight-inclusive practitioners did not include clinicians such as physiotherapists, kinesiologists, and nurses. I had also intended to recruit a racially diverse sample, but only a quarter of the sample were persons of colour. Many of the dieticians I recruited were in private practice and noted that their patient base was primarily White. Moreover, I was able to recruit patients from only six out of the 22 participating practitioners; the remaining practitioners were unable to recruit patients either due to a lack of patient interest or restrictions on recruitment. Some clinicians, particularly doctors, were located in provinces outside of British Columbia, where ethics approval could not be granted for the recruitment of their patients. Furthermore, some practitioners were unable to disseminate e-fliers to patient mailing lists due to privacy issues, and had to rely exclusively on posting flyers in the clinic space. In-person visits were reduced because of the ongoing COVID-19 pandemic, in turn affecting recruitment efforts.
Another potential challenge I had accounted for while designing the study was respondent bias, particularly social desirability bias (Dodou & de Winter, 2014; Fisher, 1993). This bias refers to participants responding in a way that presents themselves in the best possible light, in order to gain respect and social approval (Fisher, 1993). I considered the possibility that healthcare practitioners in my study might feel compelled to provide certain answers that fit the model of social justice, particularly because they had self-identified as advocates of social justice. However, by asking them not only for their views on social justice but also for concrete, in-depth examples of how they operationalized such principles, I was able to explore the tensions between theoretical assertions and practice. A related problem I had envisioned was not being able to find truly exemplary practices of social justice. While practitioners’ accounts of social justice varied and did not always align with the theoretical framework of critical consciousness and structural competency, I used the opportunity to highlight the ambivalence they grappled with, as well the barriers that might have hindered them from translating their awareness into practice. Ultimately, I view social justice as a continuum in which people are striving towards ethical progress rather than a binary of succeeding and failing.
In Canada, as with other nations across the globe, institutions such as the media, public health, and the medical profession have disseminated messages warning us against an ongoing obesity crisis (Alberga et al., 2016; Monaghan et al., 2018). While there are contesting viewpoints on the phenomenon of obesity, the dominant biomedical model considers obesity to be a pressing problem linked with various conditions such as diabetes, heart disease, and cancers, amongst others (Lupton, 2013). Furthermore, obesity is deemed as both a disease and a preventable risk factor for disease, marking obese individuals as irresponsible and morally deficient citizens (Medvedyuk et al., 2018). In Canada’s universal healthcare system, the failure of obese individuals to make healthy choices has been construed as imposing a burden on the public at large (Medvedyuk et al., 2018). News reports in Canada have highlighted the economic burden of obesity on taxpayers, characterizing the obese not only as unhealthy but expensive (Glenn et al., 2013).

This dominant biomedical approach typically explains obesity’s root causes in terms of individual-level factors such as lifestyle choices and biology (Saguy, 2013). Some scientists continue to subscribe to the ‘energy in, energy out’ model, in which food intake and exercise determine whether the body retains or loses fat, whereas others focus more on biophysiological pathways such as fat genes, inflammation, and hormonal imbalances (Yoshizawa, 2012).

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1 As noted on p.vi, this chapter has been published in Social Science and Medicine - Qualitative Research in Health on July 21, 2022. Please see the online version here: https://www.sciencedirect.com/science/article/pii/S2667321522000993. Please note that references have been removed from the end of the manuscript and amalgamated into the references section at the end of the dissertation.
Individualistic beliefs around obesity etiology emphasizing personal responsibility have been found to drive weight bias amongst diverse health professionals including doctors (Sabin et al., 2012), nurses (Mulherin et al., 2013), physiotherapists (Setchell et al., 2015), and dieticians (Stone & Werner, 2012). In healthcare settings, healthcare professionals’ weight bias has resulted in them building less emotional rapport (Gudzune et al., 2013), and providing less health education (Bertakis, & Azari, 2005) and fewer screening tests (McBride et al., 2019) for larger patients. Research suggests that weight-based discrimination has many deleterious effects on patients’ quality of life outcomes even after controlling for Body Mass Index (BMI), indicating that the harms of stigma can be greater than being larger bodied in itself (Sutin et al., 2015). The negative outcomes of stigma include a heightened risk of mental health issues, reduced physical activity (Lessard et al., 2021), healthcare avoidance (Drury & Louis, 2002), poorer management of chronic disease, increased functional disability (Potter et al., 2015), reduced income, and increased risk of poverty (Ernsberger, 2009).

In light of the pervasiveness of weight-based discrimination and the numerous consequences for wellbeing, some researchers have advocated for obesity to be understood through a social justice lens to counter the dominant approach of individual accountability (see Azétsop & Joy, 2011; Nutter et al., 2016; Taylor, 2018). However, there is a divergence amongst social justice researchers on obesity’s definition, causes, and solutions. Underlying such debates appears to be a divide between realist and constructionist perspectives. The realist approach regards obesity as a material reality warranting medical and public health interventions and notes that “the highest rates of obesity occur among the most disadvantaged individuals—those who experience disadvantage in two or more areas of inequity” (Nutter et al., 2016, p. 6). Researchers adopting a social justice lens, however, shun individualistic ideologies that hold larger people
culpable for their weight, instead underscoring the need to address the social determinants of weight such as financial stress, traumatic stress, racism, health literacy, as well as access to healthcare, quality food, recreational opportunities, and health resources (Azétsop & Joy, 2011; Molina et al., 2018; Bell et al., 2019). It is postulated that these social factors influence adiposity both in terms of shaping health behaviours such as “poor dietary [choices] as a form of stress coping” (Bell et al., 2019, p. 871) and triggering biophysical changes such as “immune inflammatory processes (e.g., increased C-reactive protein) and dysregulated functioning of the hypothalamic-pituitary-adrenal axis (e.g., elevated stress hormone secretion such as cortisol)” (Molina et al., 2018, p. 1475).

The constructionist approach asserts that obesity is socially engendered rather than a pre-existing truth (see Rich et al., 2011). These researchers highlight that the war against obesity has its roots in systemic racism, slavery, and colonialism, illustrated in how so-called inferior races have been vilified as unruly, primitive, and lacking in self-control for not conforming to White, middle-class norms of thinness and consumption (Guthman & DuPuis, 2006; Strings, 2019). They also critique the problematic history of BMI, outlining how it was introduced as a tool to determine the features of the average (White) man, and subsequently used to justify eugenics and preserve the superiority of Whiteness (Harrison, 2021; Strings, 2019). This reliance on the geneticization of race continues to play out in contemporary discussions around the negative health outcomes of non-dominant racial groups (McPhail, 2017; Strings, 2019). Rather than address how health inequities are entrenched in racist practices and policies within and beyond healthcare, the bodies of non-dominant racial groups have been marked as riskier because of their poor lifestyle choices and fat-hoarding thrifty genes (Harrison, 2021; Poudrier, 2018).

Subverting the dogma of obesity science, Poudrier (2018) suggests that “the thrifty gene can be
seen as a story – a cultural product – about disease, Aboriginal people, and genetics” (p. 257) that serves to “[legitimate] paternalistic and regulatory management over Aboriginal health” (p. 241). Given the oppressive roots and consequences of these discourses around body weight, the social constructionist perspective argues that critically interrogating these discursive processes should take precedence over addressing the material condition of carrying extra weight (Guthman & DuPuis, 2006).

Despite the theorizing about obesity and social justice, to-date no empirical research has examined the views and experiences of 1) social justice-oriented healthcare practitioners who work with larger patients or 2) larger patients who receive social justice-informed care. In the context of this paper, I refer to social justice in practice as bridging the micro-macro divide: addressing intersecting macro-level inequities such as poverty, racism, sexism, and sizeism through micro-level, patient-practitioner interactions (Mishler, 2005). This article fills a research gap by featuring interviews with healthcare practitioners who describe themselves as adopting a social justice approach to caring for larger patients, as well as with self-identified larger patients of these practitioners. Drawing on a critical realist theoretical framework, I uncover the ontological and ideological underpinnings of varying understandings of weight and health in both the extant literature and my participants’ accounts. I conclude by considering how participants’ understandings of weight and health impact clinical practice, particularly in terms of whether social justice goals are served.

5.1 Theoretical Framework and Review of the Literature

Critical realism is an ideal framework for understanding multifactorial health conditions because it transcends both biological and social determinism. Bhaskar (2008), the founder of
critical realism, posits that a reality independent of human perception exists a view known as ontological realism. Ontological realism includes corporeal realism – the notion that bodies have their own ontology (the nature of being) that is irreducible to the socio-cultural realm (Bates, 2015). Drawing on critical realism’s key concept of emergence, I position fat as an emergent quality with powers and properties that cannot be reduced to any one of its constituent parts (e.g., biology or culture) (Yoshizawa, 2012). Fat occurs not in a closed system such as a laboratory with controlled variables, but in the real world which is an unpredictable and complex open system containing a range of countervailing and complementary mechanisms that modify the effects of fat on the individual (Yoshizawa, 2012). From this perspective, fat can potentially do harm or good, but cannot be understood in a decontextualized manner; fat is the materialization of commingling biological, behavioural, socio-cultural, economic, and environmental factors (Rice, 2015).

Using critical realist principles, I demonstrate that the various perspectives on obesity are underpinned by two spectrums: 1) a realist-constructionist ontological spectrum and 2) an individualist-environmental ideological spectrum. In terms of ontology, the realist end regards obesity as a scientific truth and the constructionist end considers it to be a socially engendered fiction (Patterson & Johnston, 2012). The ideological spectrum involves: 1) individualistic ideologies focusing on personal lifestyle and biology and 2) structuralist and collectivist ideologies expanding the focus to environmental and socio-cultural factors (Lupton, 2013; Patterson & Johnston, 2012).
5.1.1 Anti-Obesity Biomedical Perspective (realist, individualist)

The dominant perspective on obesity undertaken by medical and public health authorities is a realist approach that pathologizes adiposity. These scientists see obesity as an epidemic to be fought, and mainly offer individualistic solutions to weight gain (see Belsham et al., 2020; Zhang et al., 2019). For example, Belsham et al. (2020) contend that “bariatric surgery is currently the most effective treatment for obesity, where weight loss primarily results from the increased secretion and combined peripheral and central effects of multiple hormones that reduce food intake” (p. 1).

Most of the empirical research on healthcare practitioners’ understandings of obesity aligns with the anti-obesity biomedical perspective, reflected in practitioners’ belief that larger patients are blameworthy for their weight and that obesity can be fixed through willpower and lifestyle changes (Schmied et al., 2011; Stone & Werner, 2012). Even practitioners who did not want patients to perceive them as being unduly focused on weight believed that patients should take responsibility for their excess weight (Blackburn & Stathi, 2019). Research with patients also sheds light on the prevailing weight management discourse and the ensuing feelings of shame that patients experienced due to their inability to lose weight, especially after multiple failed attempts to achieve their goal weight (Homer et al., 2016; Lewis et al., 2011; Rand et al., 2017). Even though patients were aware of socio-cultural factors that impeded their ability to lose weight, they ultimately blamed themselves for their weight status (Kirk et al., 2014).

5.1.2 Anti-Obesity Environmental Perspective (realist, environmental)

Like the dominant biomedical perspective, the environmental perspective is realist in that it views obesity as a real health risk (Lupton, 2013). However, it shifts the focus away from
blaming the individual towards an obesogenic environment, which refers to an environment that normalizes poor food and activity choices, thereby increasing obesity prevalence (see Bell et al., 2019; Berlant, 2007; Yancey et al., 2006). As Yancey et al. (2006) proclaim, “a focus on environmental causes may be particularly beneficial in reducing overweight and obesity among the demographic segments of the population that are at highest risk” (p. 432). This perspective defines obesity as a social disease, and deems behaviours such as eating as “a kind of self-medication through self-interruption, […] a fitting response to a stressful environment” (Berlant, 2007, p. 777).

In line with this framework, research by Withall et al. (2009) examined socio-cultural and environmental barriers to nutritious eating and physical activity amongst low-income families with overweight and obesity in the United Kingdom. Both parents and healthcare practitioners interviewed in the study expressed that the key factors undermining healthy lifestyle choices were related to the availability and cost of healthy foods and exercise facilities. Similarly, in Lemamsha et al.’s (2018) interviews with healthcare practitioners and community leaders in Libya, participants spoke to the notion of “politically unstable and unsafe environments” (p.10) that created more sedentary lifestyles.

5.1.3 Critical Biomedical Perspective (both realist and constructionist, both individualist and environmental)

The critical biomedical perspective shares features with the dominant biomedical approach in acknowledging some association between weight and health. While these researchers retain the realist elements of science, they integrate constructionist insights by exploring how science is underpinned by power and politics (see Campos, 2011; Gard & Wright, 2005; Oliver, 2006). For example, Oliver (2006) highlights that “the very same people who have
proclaimed that obesity is a major health problem also stand the most to gain from it being classified as a disease” (p. 6). Critical biomedical researchers draw on scientific literature to challenge the claims made by the dominant anti-obesity perspective (Lupton, 2013). In Flegal et al.’s (2013) review of epidemiological studies, they note that individuals who are clinically diagnosed as overweight or moderately obese do not have an increased mortality risk as compared to individuals with normal weight. Other researchers contest the straightforward relationship between weight and mortality, suggesting that dimensions such as stigma, culture, socio-economic status (SES), and geographical location modify the effects of body weight on health (see Ernsberger, 2009; Sutin et al., 2015). They highlight how weight stigma can spike the stress hormone cortisol (Tomiyama, 2014), and lead to poor health behaviours such as disordered eating, alcohol use, and sleep disturbances (Lee et al., 2021). Furthermore, they suggest that the weight-related variable responsible for increasing mortality risk is weight cycling, which implicates the weight-loss industry for perpetuating the very health risks that it purports to alleviate (Rich et al., 2011). They also note that most weight loss interventions do not result in sustained weight loss, urging public health programs to establish health outcome measures other than weight and BMI (Dorfman & Wallack, 2007). Many of these researchers adopt a health at every size (HAES) approach, choosing to focus on health rather than weight (see Rich et al., 2011). The original HAES movement has been criticized for being individualistic and positioning health - rather than weight - as a moral imperative (Lupton, 2013). However, HAES has continued to evolve, and many within the movement now adopt a social justice lens that situates behavioural choices within broader structures (see Burgard, 2009 for a counter-response to HAES critiques).
Concordant with this critical approach, General Practitioner participants in Malatzky and Glenister’s (2019) study subverted the realist discourses of obesity as an epidemic and scientific definitions of normal weight ranges, as well as the moralistic assumption of larger patients being ill-disciplined. Similarly, research with patients by Buxton and Snethen (2013) found that patients felt healthy despite their diagnosis of obesity. Their definitions of health were based on factors such as their ability to do what they desired and whether they experienced any chronic medical problems, rather than their BMI.

5.1.4 Critical Fat/Weight Studies Perspective (environmental, constructionist)

There is some congruence between the critical biomedical and critical fat/weight studies perspectives, though the latter takes a stronger political stance against obesity science (see Cooper, 2010; LeBesco, 2001; Saguy & Almeling, 2008). Many of these researchers are influenced by post-structuralist perspectives, and focus primarily on interrogating the power relations underlying obesity discourse (Lupton, 2013). Some critical fat/weight studies researchers view the obesity epidemic as a moral panic intended to scapegoat certain cultural groups for failing to emulate standards of thinness (Patterson & Johnston, 2012). Others acknowledge that for some people who fall at the far end of the weight spectrum, fat can pose health problems that should not be trivialized; however, they argue that definitions and understandings of a health problem are intricately intertwined with the broader social context (see Rich et al., 2011). Using concepts such as fat acceptance, the critical fat/weight studies perspective “seeks to expand the understanding of fatness beyond the narrow confines of medicalization or pathology, which is why the term ‘obese’ is frequently censured” (Cooper, 2010, p. 1020).
Correspondingly, some empirical research has contested the prevailing assumption that larger people desire to lose weight and showcased participants’ journey from shame towards pride (Gailey, 2012). In Pausé’s (2014) collection of stories featuring the experiences of self-identified fat women in healthcare, some participants positioned the war against obesity as a war against fat people and expressed their satisfaction with their body size and disregard for weight loss. Similarly, in his interviews with fat men, Monaghan (2008) found that many participants labelled as obese by the medical establishment rejected the use of BMI as a measure of their health.

Collectively, the research indicates that obesity is a contested and complex condition (Blackburn & Stathi, 2019; Bombak, 2014; Campbell, 2021). The majority of studies demonstrate that healthcare practitioners display anti-fat bias rooted in individualistic and biologically deterministic conceptualizations of weight and health. A smaller body of research has examined practitioner and lay perspectives on how socio-cultural factors shape the relationship between weight and health; nevertheless, much remains unknown about how a social justice lens shapes care for larger patients. By featuring the perspectives of practitioners and larger patients working within a social justice framework, this article explores how understandings of obesity – what it is, what causes it, and its consequences – influence how clinicians practice healthcare generally, and socially just care more specifically.

5.2 Methodology

5.2.1 Self-reflexivity in Language

Scholars interested in weight-related issues have debated the use of language to describe bodies that deviate from weight normative standards (Campbell, 2021). While the dominant biomedical model tends to use ‘obesity’ and ‘obese’ uncritically, many critical fat/weight
scholars use terms such as ‘fat pride’ (see Cooper, 2010; McPhail & Orsini, 2021). Research with patients likewise indicates that language around weight is divisive, and that there is no universally empowering term (Volger et al., 2012; Ward et al., 2009). During the interview process, I have centred patients’ perspectives by asking patients to self-identify with descriptors. In light of the diversity in patients’ preferences around weight-related terminology and the polarizing nature of ‘fat’ and ‘obese’, I use ‘larger-bodied’ when writing about patients’ collective experience. Although I oppose the unreflexive use of obese, and advocate for fat acceptance, I do not myself identify as fat and hence do not use it as an identity descriptor. Given that fat is a politically and emotionally charged label, I believe that individuals should decide for themselves whether to take ownership of the term. When using the term fat, I refer to fleshy matter, as well as participants’ own characterizations. I use the term obesity to encompass and bring into dialogue the competing discourses around the phenomenon, including the dominant biomedical and critical fat/weight perspectives.

5.2.2 Data Collection: Interviews

I conducted in-depth semi-structured interviews with a total of 42 participants based in Canada - 22 healthcare practitioners and 20 patients of the same practitioners. Each interview was between 45 minutes to 1.5 hours long and conducted over the phone or Zoom, allowing participants from different provinces across Canada to be recruited. To explore the relationships amongst understandings of social justice, weight, and health, practitioners and patients were posed with a structured list of questions about their definitions of social justice in practice, their preferred terms for discussing weight, and their thoughts on the term obesity. Practitioners were also asked about their stances on discussing weight management with patients, and patients were asked about how, if at all, they felt their weight affected their health, and their weight-related
experiences in the patient-practitioner dynamic. Given the dynamic nature of semi-structured interviews, follow-up and clarifying questions were tailored to what participants initially disclosed and emphasized during the discussion.

I used a combination of methods for recruitment, beginning with purposive sampling of practitioners. Firstly, using online search engines, I generated a preliminary list of Canadian healthcare professionals who self-identified as advocates of social justice and/or weight-inclusive approaches in their public profiles. Practitioners were included only if they confirmed with me over email correspondence that they interacted with larger patients, and/or dealt with weight-related issues. Secondly, I adopted the healthcare practitioner liaison approach which relies on personal contact from a fellow healthcare practitioner to recruit participants (Asch et al., 2000). One of my doctoral committee members, an influential physician-activist, assisted with recruitment by connecting me with other social justice-oriented practitioners. Thirdly, I employed snowball sampling, requesting the healthcare practitioners I had identified to refer other relevant practitioners. To examine the intersections amongst the lived experiences of weight stigma and socially significant categories, particularly race, gender, and class, where possible I targeted clinicians of colour and those whose profiles indicated that they worked in community-based settings, which were more likely to serve diverse communities. After selecting clinicians, I sought their assistance with posting flyers at their clinics and/or sending out e-flyers to patient electronic mailing lists. All patients in the study were recruited from 6 out of the 22 participating practitioners; the remaining practitioners were unable to recruit patients either due to a lack of patient interest or restrictions on recruitment. The flyers provided an overview of my study and invited patients who self-identified as fat, large, overweight, or living with obesity to contact me. This approach corresponds with critical fat/weight studies which avoids BMI or
other physical measurements of participants as inclusion criteria and emphasizes patient self-definition (Bombak et al., 2016). I provided $50 to each patient as remuneration for participation as part of an equity approach for marginalized communities (Collins et al., 2017). The study was approved by the University’s ethics review board, and all participants provided written informed consent. I have assigned all participants with numeric identifiers (10XX and 20XX) to protect their identities. The breakdown of participants’ demographics is represented in supplementary Figure 1.

5.2.3 Data Analysis

I transcribed the interviews verbatim and then read through them at least thrice to familiarize myself with the data. The data was examined using critical thematic analysis (Lawless & Chen, 2019), an approach that attends to macro issues of power hierarchies and social inequities in interview discourses. I drew on Smith and Elger’s (2014) critical realist approach to making sense of data which is pluralistic and integrates deduction and induction, yet begins deductively with theory. A deductive coding scheme was developed a priori based on the theoretical framework, literature review, and research questions. In particular, the different models of obesity outlined in the literature review and theoretical framework were used as a heuristic for categorizing participants’ perspectives. The overarching research questions that directed the analysis were: How do participants understand weight and health? What are the ontological and ideological assumptions that inform participants’ understandings? To what extent do these understandings of weight and health serve the goal of practicing social justice in healthcare?
Practitioners and patients were divided into two samples, and each sample was analyzed separately. Preliminary themes were deductively identified and applied to a few transcripts from each sample, with corresponding codes then assigned to each theme. Themes and codes were then refined, combined and/or subsumed under others. With a comprehensive code manual in place, the initial and remaining transcripts were (re)examined. At the same time, the transcripts were coded inductively to examine the repetition, recurrence, and forcefulness of themes (Owen as cited in Lawless & Chen, 2019). The themes from the two samples were then compared for similarities, and the data analysis was centred on the common themes across the two samples to underscore the alignment between practitioners and patients, while exploring the nuances in perspectives. My two doctoral supervisors independently reviewed and critiqued the preliminary themes and findings to enhance analytic rigour.

5.3 Findings: Attitudes Toward Weight and Health Exist on a Continuum

Using critical realism as a framework, I demonstrate how participants’ diverse perspectives reflect broader debates around individualism vs. structuralism and realism vs. constructionism. Participants’ commitment to social justice manifested in their efforts to counter individualistic framings of obesity with a structuralist understanding of weight and health. However, participants differed in their ontological assumptions, which existed on a realist-constructionist continuum of embracing to rejecting obesity as a disease. While participants held a common understanding of health as a multi-faceted construct that transcended weight and weight-related factors such as diet and exercise, there were some distinct elements in their perspectives that I have distilled into three main themes: 1) a compassionate understanding of obesity as a disease; 2) a healthy skepticism about weight management; 3) reclaiming fat as a political stance.
5.3.1 A Compassionate Understanding of Obesity as a Disease

Slightly over a quarter of the practitioners adopted the realist stance that obesity should be recognized as a disease, even though their emphasis on the connection between weight and health varied; physicians were more likely than other practitioners to align with this disease model. One doctor suggested that fat acceptance had limitations because obesity posed real health risks that could negatively impact a person’s quality of life and wellbeing. While he saw value in the “willingness to love who you are now”, he believed that it “doesn't mean you have to accept the disease process or something that is shortening your lifespan and ruining your quality of life. [...] You have to find this sort of balance [...] between self-acceptance but not necessarily disease acceptance” (1020).

The same practitioners believed in the value of weight management, but eschewed individualistic and guilt-inducing approaches associated with the dominant anti-obesity model. Instead, they pointed to the complex interplay of biological and environmental factors that influenced weight. One doctor reflected that “a lot of patients who struggle with weight perceive themselves to be to blame for it. [...] That is a mistaken view, which [...] reduces a problem down to only one of many factors” (1019). Another doctor appeared to use the disease model as tool for moving towards a collectivist understanding of health:

If we don't recognize obesity is a disease then [...] we're stuck without having the health care system take any responsibility for it [...] the blame will be resting solely on the shoulders of the individuals struggling with this problem. (1020)
Slightly less than half of the patients likewise embraced the disease model as an alternative to the logic of individualized responsibility. One patient explained how this approach was a way of freeing herself from blame:

Disease is actually a […] safe way out, […] because we know that […] there are a lot of factors in a lot of situations [around weight]. And sometimes it is just our own ignorance that we become fat but not always. (2010)

Another patient drew linkages between obesity and addictive diseases, debunking the notion that addiction was a personal choice made by the weak-willed:

Would you say that to a drug addict […] or… to an alcoholic? […] Obesity is a disease. This is something that changed your brain chemistry. It's not as easy as willpower. […] It needs help just like these other things […]. (2011)

Furthermore, it was the collective and personal trauma associated with the word fat that compelled a couple of patients to seek comfort in the language of obesity. One patient expressed: “[…] Growing up as a kid, I was always called fat […] And so […] I prefer obesity” (2009). He was not optimistic that meanings around fatness would shift significantly: “I honestly don't think that society […] will accept the word fat as a positive thing.” (2009). Similarly, another patient emphasized her preference for the term obese over fat because “if you say are overweight or obese, […] it's more […] professional […] And it's kind of less judgment that way” (2015).

All patients who saw obesity as a disease conveyed that the journey from shame towards self-compassion would facilitate healthy weight loss. For example, one patient sought to let go of unrealistic weight loss standards: “we have a preconceived idea of how much we think we're going to lose, or we want to lose, and then our anxiety accelerates if we don't meet those self-imposed targets” (2013). At the same time, she underscored that health encompassed emotional
and mental health and that an excessive focus on weight would result in her “mental health […] taking a hit” (2013). Another patient explained that weight loss could be achieved indirectly through establishing a healthy routine: “It's not […] a regime to get you to lose weight, it's a roundabout way to […] change your lifestyle so that you will automatically eat better, the weight will come off, and […] stabilize at your ideal weight” (2018). Even though weight loss was a goal, she regarded health as a broader construct that included a mindset of acceptance around various emotional and physiological restrictions: “I can only do what my body will allow me and I have […] to reach a level of acceptance. […] Once I've reached that level of acceptance, then […] that is my level of health” (2018).

Participants who understood obesity as a disease saw weight gain as reflective of other underlying issues, both internal and external to the individual. In their view, being compassionate entailed taking a collectivist approach to addressing both lifestyle and environmental factors affecting weight.

5.3.2 A Healthy Skepticism about Weight Management

Approximately one quarter of the practitioners appeared to have an ambivalent relationship with the medical model of obesity which they neither wholeheartedly accepted nor disavowed. This ambivalence did not necessarily represent a political stance against obesity, and some practitioners accepted the realist positioning of obesity as a disease, yet drew on the constructionist notion that obesity science was a contested terrain that should not be blindly embraced. For example, a General Practitioner explained that it was “so hard [to take a clear stance on obesity…]. You don't always necessarily trust the research […] because […] there's such a prevalence toward […] anti-fatness […].” At the same time, she was not opposed to the
idea that weight loss may confer some benefits and admitted to her limitations: “I don't know all the science behind it” (1014).

About one third of the patients also expressed uncertainty about the weight-health relationship. One patient conveyed her desire to lose weight yet recognized that weight loss was no guarantee that she would alleviate other health problems: “I just don't know if it's […] going to make that much of a difference for me […] so this is an experiment for me [to] see if I can reverse the diabetes, or at least put it at bay [by losing] considerable weight” (2018). Another patient described how she had internalized messages that carrying more weight would lead to health problems, yet remained skeptical about the accuracy of such messages:

“I wrestled with [whether weight is connected to health…], I say to some degree, it must be related, but I don't think it's all about it […] I carry more weight and […] have chronic pain and so I wonder [if] carrying more weight must have an effect on that. [But] I don't know, it's just those [messages] that get to you. (2020)

These accounts highlight that patients’ pursuit of weight management was not necessarily motivated by observing a clear health benefit from weight loss; furthermore, their goals could sometimes be shaped in part by pervasive socio-cultural norms that elevate thinness and demonize fatness.

Approximately one quarter of practitioners grappled with medical terminology even though they did not entirely abandon the realist framing of obesity associated with the biomedical model. One General Practitioner who supported fat acceptance nevertheless continued to use BMI as a concerted attempt “to move away from [the use of the term obesity]”. She reasoned that BMI, while problematic, was better than relying on weight alone which did not account for height:
I want people to understand that for your height, a particular weight may put you at slightly higher risk. Because I think we do have the data to suggest that. I just think we can't be as dogmatic about it as [...] medical system has been historically. (1017) This perspective suggests that rather than taking an all-or-nothing approach to systemic change, practitioners sometimes had to work with the constraints of the system to find spaces of resistance to practice more equitably.

A couple of patients were likewise averse to the term obese but more receptive to other medical terms such as overweight. One patient articulated that she was “trying to get away from the weight idea” though she did not appear to be impervious to a weight-based norm:

I would prefer overweight compared to obese because obese to me, means that [...] you're way [emphasis in original] beyond levels, whereas overweight to me [...] is only maybe about [...] 30 pounds or 35 pounds over [...] your ideal weight [emphasis added] (2008).

Given their ambivalence around obesity science, these practitioners and patients shifted their focus from weight to health; furthermore, the vast majority shunned individualism, instead acknowledging the broader determinants of health. One patient explained the importance of avoiding simplistic causal explanations in which health problems were immediately attributed to weight: “[I would like to see practitioners] really try and understand [...] the world you live in [...] Is it familial? [...] Is it your genetics [...] Is it work? [...] Just making sure they go through all the factors” (2003). Likewise, a dietician emphasized that “weight is only one measure of health and the one we tend to focus on the most, but it’s much more important to get into healthy rhythms of meals and activity and then our body gets to a weight that it’s comfortable with” (1005). At the same time, she was careful not to responsibilize lifestyle choices, noting that
patients’ social positions could impede their ability to engage in self-care: “people [didn’t] know where the food supports were […] So much of our health is connected to social connection […] Healing happens much faster in a social setting when there are good connections” (1005).

These attitudes questioned some of biomedicine’s existing claims around weight, particularly the notion that BMI was necessarily reflective of individual health, and prioritized health as a more important pursuit than weight management. In line with a collectivist and structuralist approach, participants understood health as circumscribed by the broader socio-cultural context rather than an individual responsibility.

5.3.3 Reclaiming Fat as a Political Stance

Over half of the practitioners adopted an approach of politicizing fat that overlapped with skepticism around weight management but went further in disrupting the weight-health connection. Adopting a social constructionist lens, these practitioners contended that the problem was not the fat body itself but the social attitudes, practices, and policies by which fat people were oppressed. They thus believed that fighting fat oppression superseded weight management and pursued this goal by exploring fat phobia with patients. In the words of a social worker, social justice involved:

Putting [patients’] struggles in the context of the diet culture they live in, to really validate for them that […] their body isn't wrong […] It's all the weight stigma they've experienced in the world that's wrong. […] (1012)

The same practitioners also took an explicit ethical stance against helping patients with what they deemed as a socially irresponsible goal of weight loss. As one dietician remarked:

If [patients] are fixed on weight loss […] then I tell them […] there’s an array of dieticians who are willing to talk to you about weight loss, but I can’t help you with that.
I can help you with a whole bunch of other things that I believe will better your lives but […] weight loss because I feel it’s unethical [and harmful] to do so […]. (1002)

For their part, approximately one third of patients opposed weight management and underscored that the challenges of living in a fat-phobic and bigoted society - rather than weight per se - were what impacted their health negatively. Reflective of a constructionist approach, one patient, when asked if she thought her weight had ever affected her health, responded firmly: “No. Never. The […] biggest effect on my health has been other people's attitudes” (2004).

Another patient attested that contrary to the dominant obesity discourse, her experience of being discriminated against as a fat, woman of colour was more detrimental to her health than carrying excess weight in itself:

Going out isn't safe, […] sometimes even the idea of […] making a trip to the grocery store and […] moving my body or […] going to a park […] are impacted by […] the potential aggressions that you face. […] What are all the things I could do if I didn't have these […] limitations that have been created by this society? […] What would my standards of health be then? (2007)

Rejecting the realist notion that obesity was a biomedical fact, over half of the practitioners opposed its usage, positing that it pathologized larger bodied people. One dietician highlighted that eradicating weight stigma and obesity discourse had to go hand in hand, and that it was contradictory to claim to be anti-oppression yet subscribe to the disease model of obesity:

Generally, people think weight stigma is a bad thing. Just like they say any kind of stigma is a bad thing. But I find this sort of internal dichotomy that says weight stigma is really, really bad and so is obesity […] We haven’t sort of made that leap to the way to get rid of weight stigma…is to get rid of this obesity discourse. (1002)
About one third of patients were critical of obesity-related terminology, highlighting the role of language in shaping beliefs and experiences. One patient asserted that obesity was “a weaponized word” (2020) that incited fear mongering. Taking an intersectional lens, she problematized the racist and sexist roots of fat phobia, arguing that these stigmatizing terms were “a way of holding power […] over people of colour” who did not conform to Eurocentric ideals. She added, “gender is huge, too, because as much as [there are] issues with men being overweight, it's much more for women” (2020).

About one fifth of patients sought to reclaim the use of the word fat, and dispose of its power to wound. A patient explained that she chose to identify as fat despite others’ discomfort: “Health practitioners that I encounter use different words or kind of tried to dance around it […] but [I] just [use] the word fat.” (2001). Another patient contended that people’s well-intentioned efforts to reassure her that she was not fat were part of an anti-fatness culture: “The most derogatory thing I feel you can say to some people is […] fat […] People's immediate reaction is […] oh no, you're not fat […] I'm not looking for you to try and make me feel better” (2006).

However, it is important to note that the act of reclaiming fatness was not a straightforward process, and participants struggled with internalized and external fat phobia. Both practitioners and patients who believed in fat acceptance were mindful of other people’s comfort levels when using the terms. As one dietician noted: “If someone is comfortable, I will use fat [as an identity descriptor] but […] most people are not comfortable […]” (1004). A patient conveyed that even when using the term on herself, she had to consider others’ discomfort and manage their emotional responses: “[…] Sometimes I feel bad using [fat] because other people are uncomfortable using it. And sometimes I don't feel like I have the
energy to explain why I call myself fat […]” (2002). Furthermore, a couple of patients suggested that although they supported the strides made against body shaming by the fat acceptance movement, they found the word fat imbued with too much negative cultural and emotional baggage to be personally reclaimed. For example, a patient who spoke about the power of reclaimed language and had reclaimed the term “dyke” herself admitted: “I don't want my name put straight on […] fat…]. I'm not there yet. […] My dad used it in a very mean way […] so there's a sting to it for me” (2018).

Those who saw fat as a political issue shared a common goal with weight management skeptics to move away from weight towards health as a multi-dimensional construct encompassing both individual and macro-level factors. However, this perspective drew more on social constructionism in uncovering the politics of obesity discourse (Guthman & DuPuis, 2006) and in exploring the potential of fat be reclaimed (Cooper, 2010).

5.4 Discussion and Conclusion

In this paper, I have used critical realism as a framework to identify three main themes in my data: a compassionate understanding of obesity, a healthy skepticism around weight management, and reclaiming fat as a political stance. The first approach attempts to offer a more humane and holistic understanding of obesity as a disease to mitigate individualistic blaming and shaming attitudes towards larger people, yet retains the dominant anti-obesity approach’s preoccupation with “the most effective way to combat this ‘problem’ or ‘epidemic’” (Gotovac et al., 2020). The second is characterized by an ambivalent relationship with obesity discourse, and channels attention away from weight-oriented outcomes towards factors that improve patients’ health, independent of weight loss. The third has a similar de-emphasis on weight loss, but
adopts an explicit political stance in which truly eradicating weight-based oppression means dismantling the discourse of obesity and its associated terms.

This study makes a unique contribution to the literature in featuring the perspectives of larger patients and their practitioners who described themselves as social justice oriented and/or weight-inclusive. In contrast to the majority of prior research on healthcare practitioners’ views around obesity (see Saldaña-Tejeda & Wade, 2018; Sikorski et al., 2013), practitioners in this study avoided individualistic and biologically deterministic ideologies, and accounted for the broader determinants of weight and health. However, their social justice orientation manifested in different ways depending on their ontological understanding of obesity as either primarily a social construct or a biomedical fact. Given the power differentials between practitioners and patients (Goodyear-Smith & Buetow, 2001; Nimmon & Stenfors-Hayes, 2016), practitioners’ perspectives on obesity likely impacted how patients perceived their own bodies and health. Collectively, patients’ and practitioners’ views on obesity correspond with a range of earlier studies indicating that participants displayed an awareness of the environment and structural roots of obesity (Withall et al., 2009), the need for compassionate and non-judgmental support around weight management (Chugh et al., 2013), and the social construction of the obesity epidemic (Malatzky & Glenister, 2019; Pausé, 2014). Furthermore, patients’ accounts revealed that contested terms such as fat and obese were neither uniformly empowering nor disempowering. As previous research has shown, some larger patients considered fat to be their least desired term (Dutton et al., 2010; Volger et al., 2012), though other patients viewed the term obesity to be more stigmatizing (Ward et al., 2009). With that said, findings must always be contextualized within their research design. Some researchers may uncritically endorse the use of BMI (Gotovac et al., 2020) and use it as an eligibility criterion for participation, thereby
alienating patients who do not subscribe to obesity discourse. While the findings in this study as well as prior research (Chugh et al., 2013; Malterud & Ulriksen, 2010) suggest that not all larger patients perceived weight management as an inherently oppressive goal, it is equally important to feature the perspectives of patients whose self-defined goals depart from the dominant weight-centric model. Integrating diverse and divergent accounts of embodiment in research allows for the representation of expansive human experiences of pleasure, possibilities, affliction, and ambivalence (Meleo-Erwin, 2012).

This study advances a critical realist-informed understanding of weight and health, and uncovers how different ideological and ontological assumptions about obesity shape the way social justice is experienced, understood, and enacted. Drawing on the concept of corporeal realism, I regard the physical challenges surrounding weight articulated by participants to be ontologically real, rather than reduce their existence to a social construction. At the same time, I do not underestimate the power of discourse; individuals are not immune from hegemonic influences, and may internalize messages that shape how they experience and understand their bodies. From a critical realist perspective, incorporating social justice into health interventions requires practitioners to integrate into their care a combination of clinical knowledge of biological systems with a structural analysis of social-cultural realms (Bourgois et al., 2017). This approach opens up spaces to disrupt the dogma of obesity science, leaving room for the unknown or uncertain – causal mechanisms that have yet to be observed, measured, or understood (Martinez Dy et al., 2014). Although the biomedical model of obesity and fat acceptance are often presented as opposing forces (Warin, 2015), participants in this study sometimes displayed ambivalence around obesity discourse. As “subjects-in-perplexity” (Ramamurthy, 2003, p. 543), individuals are not shaped by a static, singular ideology, and
instead actively engage with contesting, overlapping ideologies. This perplexity can be seen as part of a burgeoning critical consciousness that paves the way for socially just healthcare practice.

From a social justice vantage point, it is crucial to consider the ethical consequences of the medicalization and biomedicalization of excess weight as a disease and risk factor. Clarke et al. (2003) has described the newer process of biomedicalization as “the extension of medical jurisdiction over health itself in addition to illness, disease, and injury” (p. 162). In the post-modern era of biomedicalization, “those at risk of becoming obese are as central to the epidemic as those who actually are obese” (Boero, 2020, p. 308). This preoccupation with identifying risk has influenced epidemiological interventions targeted at low-income and non-dominant racial groups who are deemed to be at higher risk (Firth, 2012; Kirkland, 2011). Such interventions often rely on paternalistic and patronizing attitudes towards people’s low health literacy or poor awareness of health materials (Guthman, 2009), without recognizing how certain health behaviours may serve as a form of self-determination and cultural expression for marginalized groups (Subica et al., 2016). Even though the structuralist approach to obesity positions itself as a progressive alternative to the individualist account, it retains the moralistic undertones of obesity discourse and limits patients’ choices to what has been designated as desirable and healthy (see Kirkland, 2011, for a critique of the structuralist account of obesity). Furthermore, its fixation on an obesogenic environment reduces complex socio-cultural factors to the narrow pathways of how they impact food and exercise, and therefore adiposity (Rich et al., 2011). Supporting marginalized communities then becomes conflated with helping them solve their obesity problem (Kirkland, 2011) rather than understanding health as an “embodied construct that takes a myriad of forms according to social context” (Monaghan, 2001, p. 331). As
participants’ experiences demonstrate, other mechanisms such as financial strain, racism, and social exclusion may impact health in more significant ways beyond fat accumulation, which highlights the need for practitioners to holistically assess patients’ challenges, priorities, and goals. Accordingly, a social justice approach to care calls on practitioners to explore and validate patients’ real concerns about their weight without getting trapped in the dichotomy of pathologizing their bodies as diseased or as trivializing their desires as a form of false consciousness about their oppression.

5.5 Limitations and Future Directions

My study specifically focuses on practitioner-patient dyads; I recruited only patients of the practitioners who had already participated in my study. Hence, these patients’ perspectives on obesity may be influenced by their practitioners. To offer another lens into how conceptualizations of weight, health, and social justice are related, future research could recruit larger patients who themselves identify as social justice advocates. Such research would enhance this study’s findings on what clinical practices best serve the needs of larger patients; it would also contribute to a larger embodied health movement (Brown et al., 2004) that subverts hegemonic forms of knowledge, and centres patients’ voices in generating new knowledge about health. Additionally, the study was conducted in Canada, whose public healthcare system has been contrasted with the largely privatized system in the United States, where the bulk of research on weight stigma has been conducted (see Wu & Berry, 2018 for a systematic overview of studies on weight stigma). Despite the social value underlying the Canadian healthcare system that healthcare is a shared responsibility of both individuals and society, the discourse of individualism still holds profound power in the socio-cultural landscape (Donnelly & McKellin,
Thus, while the nuances between public and for-profit healthcare practice should be recognized and further explored, the study findings may still have some relevance to other Western neoliberal societies similarly characterized by tensions between individualism and collectivism. Finally, despite attempts to recruit a more racially diverse sample, only over a quarter of the sample were persons of colour. Given the racist origins of fat phobia, it is important for future weight-related research to feature the perspectives of non-dominant racial groups when examining interlocking systems of oppressions. By probing into all participants’ experiences around power, marginalization, and privilege, this study nevertheless maintains critical race theory’s key mandate to “bring race consciousness to the forefront, in contrast to the accepted model of colour-blindness, in an effort to combat the limited understanding of how racism exists within hegemonic power structures in […] society” (Johnson & Parry, 2015, p. 25).

5.6 Appendix A. Supplementary Data

Figure 1.1

![Demographic Breakdown of Research Participants.](image)

*Figure 2* Demographic Breakdown of Research Participants.
Chapter 6: Article 2: “It’s Not Just to Treat Everybody the Same”: A Social Justice Framework for Caring for Larger Patients in Healthcare Practice²

Weight bias pervades healthcare settings, evident in how many health practitioners blame and shame heavier patients (Phelan et al., 2014). Such bias is amplified by the visibility of body weight and the assumption that individuals can exert control over their weight through diet and exercise (Alberga et al., 2016). In Western neoliberal societies, such as Canada, minimal government intervention continues to be idealized and individual health practices are promoted as techniques to ward off diseases and reduce government spending (McPhail, 2017). In light of Canada’s public healthcare system, larger people’s so-called poor lifestyle choices are seen as imposing a burden on society (McPhail, 2017). Research on Canadian physicians found that half of them perceived larger patients as posing a threat to the public healthcare system, which was linked to them displaying greater weight bias and more negative attitudes towards larger patients (Alberga et al., 2019). Weight bias has been found to negatively impact the psychological and physical health and healthcare experiences of larger bodied people (Puhl & Heuer, 2010). Given these ill effects, there has been increased research on addressing weight stigma in the clinic (Scaglìusi et al., 2020).

Two major approaches to changing behaviours and attitudes towards larger patients have emerged. The first is a “macro ethics of social justice” (Mishler, 2005, p. 432), which departs from a focus on individual lifestyle and behaviour, and instead examines the effects of social and economic oppression on health outcomes. This approach has the overarching goal of enabling all

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² As noted on p.vi, this chapter was published in Sociology of Health and Illness on April 17, 2022. Please see the online version here: https://onlinelibrary.wiley.com/doi/10.1111/1467-9566.13470. Please note that references have been removed from the end of the manuscript and amalgamated into the references section at the end of the dissertation.
groups to fully participate in society (Azétsop & Joy, 2011). In the context of weight stigma, social justice emphasizes principles of equity through the distribution of health resources and services, and recognizes that these factors are often beyond individual control, especially for those belonging to non-dominant groups (Azétsop & Joy, 2011). The second perspective, a “micro-ethics of humane care” (Mishler, 2005, p. 432), attends to the micro-level experience, particularly the patient-practitioner encounter. This perspective seeks to develop practitioners’ interpersonal skills so they can enter the world of patients, listen to their stories, and respect their cultural norms and beliefs (Davis & O’Brien, 2020). While this approach humanizes the patient and attends to their subjective experiences, it tends to neglect the role of systemic biases and structural inequities (Metzl et al., 2018).

Drawing on semi-structured interviews with larger bodied patients and their healthcare practitioners, we consider both micro- and macro-ethics in providing socially just care for larger patients in the Canadian context. Theoretically, we use structural competency and critical consciousness to address how social justice is enacted, experienced, and understood in interactions between clinicians and larger patients. We note that within the literature on weight-related issues, tensions exist amongst scholars on the most appropriate term to describe bodies that fall outside weight normative standards (Campbell, 2021). Many critical fat/weight theorists reject the terms ‘obese’ and ‘obesity’, contending that the dominant biomedical discourse pathologizes fatness and reinforces colonialist, patriarchal, capitalist, and heteronormative standards of health and beauty (Cooper, 2010). Instead, they chose to reclaim the term ‘fat’ as an expression of pride and empowerment (Cooper, 2010). Research with patients similarly shows divergence in their preferred language around weight, with some considering fat to be their least desired term (Volger et al., 2012), and others perceiving the term obesity to be more stigmatizing.
(Ward et al., 2009). In line with a patient-centred approach, we have, in our interviews with patients, asked them to self-identify with terms that resonate most. We acknowledge that there is no universally accepted term and within the context of this article have chosen to use ‘larger bodied’ when writing about patients’ collective experience. While we problematize the construction of obesity as a disease and support the fat acceptance movement, we do not use fat as an identity descriptor as we are not self-identified fat people, and see fat as a culturally and emotionally fraught label that individuals should decide for themselves whether to reclaim.

6.1 Power and Privilege in the Clinical Encounter

Waitzkin’s (1991) consideration of the politics of medical encounters reveals how doctors who legitimize individualistic solutions to health problems rooted in social inequities foreclose possibilities for social change. Studies on larger patients’ interactions with practitioners likewise demonstrate the negative consequences of clinical practice exclusively focused on micro-level approaches (Stone & Werner, 2012). Practitioners neglected broader socio-structural factors that shape weight and health, and reinscribed the notion that patients have a moral duty to rectify obesity through lifestyle changes, which subsequently exacerbated patients’ shame (Webb, 2009). Building on this research, we argue that it is also important to showcase the transformative elements of clinical practice. Healthcare can be a salient platform for advancing social justice goals given clinicians’ leverage in influencing patients (McPhail & Schippers, 2012), clinicians and clinicians-in-training, and the public (Earnest et al., 2010).

A small body of research has explored clinicians’ perspectives on social justice. Gallagher and Little (2017) conducted interviews with doctors to understand the life circumstances that shaped their attitudes towards advocacy, specifically “changing practice and […] the system to address the social determinants of health” (p. 371). They found that doctors’
relationships with power – both experiencing power and powerlessness – influenced their advocacy decisions. Advocacy allowed doctors to reclaim their power in the face of limited control within the clinic by creating systems change and to find relief from their power relative to patients. Another study by Valderama-Wallace and Apesoa-Varano (2019) demonstrated that nurse educators’ racial identities featured prominently in how they understood social justice.

Nearly all White participants voiced dominant ideologies of equality (treating everyone the same) and individualism (seeing the individual as more important than their group), whereas participants of colour tended to adopt an equity framework centred on addressing the legacies of systemic injustice.

While these findings reveal how power and privilege shape beliefs and practices, little is known about how a social justice lens informs interactions between practitioners and larger patients. To our knowledge, there have been no empirical studies examining the perspectives of 1) clinicians who adopt a social justice approach to caring for larger patients and 2) larger patients who receive social justice informed care. Addressing this gap, this study features interviews with clinicians who identify as social justice oriented and larger-bodied patients under their care.

6.2 Reconciling Micro and Macro: Structural Competency and Critical Consciousness

Social justice work has often been characterized as a macro-level intervention occurring outside the clinic (Martinez & Fleck-Henderson, 2014). Research suggests that many clinicians are increasingly aware of how extra-clinical conditions lead to poor health outcomes but still feel helpless to intervene (Bourgois et al., 2017). Structural competency empowers clinicians to practice social justice through a pragmatic, solutions-focused approach that “[mobilizes] medical expertise and authority for the betterment of clinical and extra-clinical systems” (Metzl & Petty,
By integrating the broader intersecting social conditions into the medical encounter, this approach addresses the micro-macro disconnect. Clinicians are encouraged to not only consider patients’ presenting health problems, but also to identify challenges in their daily lives and resources they can leverage to overcome challenges (Bourgois et al., 2017). Given the time constraints of short appointments, not all of these efforts need to occur within clinical practice; clinicians can partner with community organizations to enhance patients’ care (Hansen as cited in Levin, 2018).

Structural competency works in tandem with critical consciousness, which refers to what Freire (as cited in Kumagai & Lypson, 2009) terms reading the world, or understanding how social relationships involve power differentials. Critical consciousness entails carefully examining one’s own assumptions, biases, and values, and looking beyond one’s own immediate circumstances to grapple with social injustices (Kumagai & Lypson, 2009). It also calls on clinicians to translate such awareness into action, for example, by correcting their own behaviours that may not be in patients’ best interests. In this study, we explore how participants’ accounts of social justice involve four main themes related to structural competency and critical consciousness.

### 6.3 Method

**6.3.1 Data collection: Interviews**

The first author conducted in-depth, semi-structured interviews with 42 participants who were asked both focused and open-ended questions. Interviews lasting between 45 minutes to 1.5 hours were conducted by phone or over Zoom, enabling recruitment from different Canadian provinces. Practitioners were asked about what social justice meant to them, their life experiences in relation to social justice, and their interactions with patients, including the
influence of their own social positions and their perceptions of key challenges. Patients were asked about what social justice meant to them, whether there were socio-cultural factors that affected their health concerns and their healthcare experiences, and whether and how they discussed such factors with their practitioners.

Practitioners were recruited using purposive sampling from a list of healthcare professionals in Canada who mentioned social justice and/or Health at Every Size\(^3\) (HAES) approaches in their profiles or media interviews that the first author compiled. Potential participants were asked to confirm that they had experience interacting with larger patients. The healthcare practitioner liaison approach which relies on personal contact from a fellow healthcare practitioner was used to recruit participants (Asch et al., 2000). A physician-activist assisted with recruitment by identifying other social-justice oriented practitioners. Finally, snowball sampling methods were used as participants were asked to refer other relevant practitioners. In line with an intersectional social justice approach, where possible clinicians of colour and those whose practice served marginalized communities including low-income groups and people of colour (POC) were sought out. Practitioners assisted with the recruitment of patients by disseminating flyers, either via their electronic patient mailing lists or around their physical clinics. The flyers invited patients who self-identified as fat, large, overweight, or living with obesity to contact the first author. This emphasis on self-identification rather than BMI is consistent with a social justice approach that recognizes bodies and identities as fluid (Bombak et al., 2016).

As an equitable practice for marginalized communities (Collins et al., 2017), patients were remunerated with $50 for participation. In our study, participants’ demographic information

\(^3\) HAES is a movement that focuses on wellbeing and health habits rather than weight management.
indicated that patients were, on average, in a lower income bracket relative to practitioners. We recognize that research compensation, particularly for structurally marginalized populations, remains a contentious practice given that participants may engage in research for financial need, while disregarding the risks of research (Dickert & Grady, 1999; Pandya & Desai, 2013). While we believe the concerns of increasing participants’ vulnerability must be carefully considered, we see the solution not as minimizing compensation but minimizing risks of harm. Prior research has demonstrated the need for “compensation protocols […] to be […] attuned to [participants’] lived realities” (Collins et al., 2017, p. 12). In Collins et al. (2017)’s focus groups with people living with HIV who use drugs, participants’ accounts underscored the misalignment between “altruistic expectations of research participation and their real material needs” (p. 6). Participants viewed research as a transactional process and were not compelled to participate purely because of interest in a research topic, even if they were open to learning about findings (Collins et al., 2017). This view of research as transactional gave participants the opportunity to shift the researcher-participant power dynamic towards fulfilling their material and monetary needs (Collins et al., 2017).

In order to reduce the potential that the incentive might pressure participants to participate even if they did not feel comfortable with the interview questions, we emphasized the informed consent process and took steps to maximize transparency and comprehension of information. Participants were informed that they could take a timeout or skip questions they did not wish to answer and were still entitled to the incentive even if they did not answer all the interview questions or withdrew from the study early.

To protect anonymity, all participants have been given numeric identifiers (10XX for practitioners and 20XX for patients). The breakdown of participants’ demographics is
represented in the figure below. The majority of the practitioners (n=22) were female, White, and Registered Dieticians (RD), and the majority of the patients (n=20) were female, White, and seen by Medical Doctors (MD).

**Figure 1**

![Figure 1](image1.png)

**Figure 3** Demographic Breakdown of Research Participants.

6.3.2 Data Analysis

All interviews were transcribed verbatim and analyzed using critical thematic analysis (Lawless & Chen, 2019), which has an explicit commitment to social justice. Drawing on Smith and Elger’s (2014) pluralistic approach to data analysis, deduction was combined with induction. A deductive coding scheme was developed from the theoretical framework, literature review, and research questions. A few tentative organizing themes, such as an awareness of one’s social identity and a recognition of the social context, were identified in advance and used as a guide for reviewing the transcripts. Three main research questions directed the analysis: 1) How do practitioners who adopt a social justice lens understand social justice in clinical practice? 2) What does social justice in clinical practice mean to larger patients? 3) How does social justice-informed care impact larger patients’ experience?
Similarly, inductive codes were generated by examining the repetition, recurrence, and forcefulness of themes that were not captured in the initial coding scheme (Owen, 1984). Some inductive codes included practitioners self-disclosing and finding common ground with patients, and patients perceiving practitioners’ thin privilege to be a barrier. During this iterative process, corresponding codes were listed under each theme as the transcripts were reviewed, with the themes and codes then refined, combined and/or subsumed under one another.

6.4 Findings

We identified four interrelated themes under the umbrella of structural competency and critical consciousness: 1) An awareness of the simultaneous experience of privilege and marginalization; 2) Navigating between additive and interactive understandings of intersectionality; 3) Addressing macro issues of injustice through micro-level interactions; and 4) Straddling the line between equity and equality.

6.4.1 An Awareness of the Simultaneous Experience of Privilege and Marginalization.

Almost all practitioners spoke about how their privileged positions impacted patient interactions. As one social worker expressed, a critical consciousness “[involves…] the practitioner being really aware of who they are […] from […] an identity perspective” (1007). She explained that as a White woman, she had to be sensitive to the power dynamics in her encounters with Indigenous and non-dominant racial communities:

I've worked with a lot of people who have had […] generations of trauma, and who may see me as […] the White person […] who's been […] part of that […] trauma […]. I have to remain in a place that's not defensive, […] that listens to what they are saying. […]

(1007)
Most practitioners perceived the unlearning of oppression and removal of privilege blinders to be a lifelong process that required humility. Over half of practitioners described how weight-bias was entrenched in health care education, which necessitated proactively and reflexively working through internalized bias:

[...] I still fight a little bit of a knee jerk reaction of [...] feeling that if somebody were to lose weight [...] that they would improve themselves. I have to always ask myself [...], would [this] honestly make a difference in their health? And if so [...] how am I gonna approach it? (General Practitioner, 1014)

Notwithstanding their high social status, approximately half of practitioners described how they were marginalized for their own body weight, sexual orientation, gender, and/or race. Notably, all practitioners of colour explained how living with racism had honed their social justice orientation. One General Practitioner highlighted that while she could connect with patients of colour over their racialized identities, having a critical consciousness was what helped her to relate to diverse patients:

In terms of identities I don't hold, I still feel like having an understanding of oppression and marginalization in my own lived experience helps me better understand [...]. It gives you a lens into how dominant culture [...] power structures work, and how that possibly might impact this person and shape their life. (1017)

Almost a quarter of practitioners recounted their struggles with weight stigma, which allowed them to avoid defaulting to dominant assumptions that lifestyle modifications could easily treat obesity. As one doctor explained, his lived experience with being larger bodied was part of why “the idea of judgment there [didn’t] resonate with [him] at all cognitively”. However, he conceded the limitations of his own awareness: “the very lens I bring myself is already marked
by such bias [even if] I'm not aware of that bias within me […]” (1019). The pressures to embody a thin ideal to maintain professional credibility appeared particularly salient for dieticians. As one mentioned: “I had an instance where an acquaintance of mine said to me, […] will people take you seriously when you give them advice because you are not a skinny dietician?” (1004).

For their part, half of patients expressed that practitioners’ thin privilege sometimes undermined the therapeutic relationship and that they felt more comfortable with practitioners who had similar experiences around weight. One patient explained how diverse representation mattered in healthcare:

A lot of the people […] they've hired [at the obesity clinic] don't have weight problems. […] They could be better in […] hiring somebody who's a little bigger in size that kind of understands. Because […] when I'm hearing a […] five foot six, Caucasian, maybe 120 pounds, telling me all this stuff about obesity, it's like, do you really know what I've gone through? (2009)

Nevertheless, a couple of patients stressed that practitioners should avoid excessive self-disclosure about their weight-related struggles to the point of overshadowing the patient experience. For example, one patient found her practitioner’s attempts to forge commonalities contrived and instead preferred an approach of humility:

Some practitioners never had weight struggles […] but they won't try to […] relate and make it seem like […] I'm one of you when they're not. They'll just honestly be like, I don't know what this is like, how do we work through it? (2015)
Another patient’s experience challenged the essentialism of identity politics, or the assumption that solidarity would *naturally* emerge from having similar lived experiences around oppression. She opined that similar experiences were not a requirement for empathy:

> […] Anyone has the ability to understand by just […] taking some time to read something, to talk to someone. […] That's the work we all do. […] That's the whole point of social justice. (2020)

As with practitioners, patients’ accounts depicted the interwoven nature of privilege and oppression. While patients were in a subordinate position vis-à-vis practitioners and marginalized because of their weight, almost all highlighted the ways that their privilege, particularly because of race and/or socio-economic status, enabled them to navigate the system. One patient expressed:

> I am very lucky in that I have stable housing. I have good access to health care. I have access to clean water and working utilities and […] I know how to cook […] and I'm able to purchase nutritious and healthy food […] I'm part of that White privilege group. (2013)

Another patient rejected the idea that she was oppressed as she noted that her privilege mitigated weight-based discrimination:

> I […] don’t really think I can describe myself as being oppressed to be honest. […] My privilege is so […] abundant [that] I don’t know if that’s the right word. [I] still [recognize] that I do have some challenges I suppose.” (2002).

### 6.4.2 Integrating the Micro and Macro

Participants’ narratives demonstrated that social justice in practice involved grappling with micro and macro approaches to change. Almost all participants challenged the view that health was the individual’s sole responsibility, emphasizing the role of structural health determinants.
When asked what social justice in healthcare meant to them, about a third of practitioners described assuming both micro and macro level roles. One General Practitioner opined that social justice had “two prongs”, the first being the “clinician to patient dynamic” and the second being the “interaction between [clinicians] and the healthcare system” (1019). He explained that the advocate role became more relevant in the second prong, where his goal was to “become a force of change for the better for the healthcare system on the whole, such that [his] patients and the populations that they represent receive equitable care” (1019).

While the other practitioners in the study did not mention engaging in macro-level advocacy, they described their work within clinical microsystems as an enactment of social justice, influenced by systemic factors. A dietician stated:

For me, it's […] not […] protests […] necessarily, but in my professional […] method and mechanisms, it's [...] educating, shifting perspectives, and advocating for the client to get the best care that they can get and not have weight stigma or other stigmas [be] present in the medical system. (1008)

The majority of practitioners opined that doing micro-level work did not mean succumbing to individualism. A dietician emphasised that personal empowerment, while valuable, had to occur in conjunction with broader societal change: “[…] Everybody can benefit from […] positive self-esteem, positive psychology, but […] it’s very demanding, it’s another thing we are putting on individuals when really, we should be addressing the oppressors, not the oppressed” (1001).

Almost all patients also displayed an understanding of the social-structural causes of health issues. One patient remarked that a social justice approach transcended interpersonal skills and required attention to systemic injustice:
For people in power, like healthcare practitioners are because they're literally the ones with the power in the room, [...] not the patient, [...] it's not enough to just [...] be nice. They have to [...] be [...] proactive about [...] addressing [...] fat phobia. (2007)

Another patient similarly contested the prevalent discourse of individualism:

If you're poor, if you don't have access to nutritious foods, clean water [...] that's going to affect your health. [...] Our medical profession likes to blame the individual, like you're not healthy because you're not eating your vegetables. (2004)

Furthermore, patients had differing levels of comfort with bringing up their social challenges. One financially stable patient noted that she did not require practitioners to ask about her ability to access resources: “I feel there's nothing untalked about [...] because otherwise I would bring it up.” (2016). However, another patient who identified as having a lower socioeconomic status struggled to broach social challenges with practitioners:

 [...] I don't really feel super comfortable saying [...] I don't have enough money for all these healthy foods, what should I do? [...] It can be kind of embarrassing [...] Having the practitioner bring it up] would probably be helpful [...]. (2014)

Almost all patients commended practitioners who proactively addressed the social determinants of health. One patient said: “they asked me if I have supports in my life, [...] if I'm on this journey by myself or if there's people [...] in my corner and I think that that would be really important to know about a patient” (2017). Another patient showed appreciation for how the clinic’s health recommendations accounted for patients' socio-cultural and socio-economic backgrounds:

They're very careful about how they [...] present foods [...] and recipes for people to cook there, as far as [...] vegetarian to different kinds of [...] eating preferences or [...]
cultural eating values, […] from those who have access to money, and those who are very limited in their budget. (2018)

6.4.3 Intersectionality: Additive or Interactive Models of Understanding Oppressions?

Almost all practitioners and patients discussed how different oppressions related to weight, race, class, sexuality, and gender, amongst others, played out in individuals’ lives. However, participants diverged in their emphasis on the intertwined or additive nature of these oppressions.

Over half of practitioners focused on the mutually constituting nature of oppressions, suggesting that weight-based discrimination had to be tackled in conjunction with other systems of oppression rather than as a standalone issue. A General Practitioner whose practice served many transgender patients described the entanglement of gender, weight, and beauty imperatives, exemplified in the way successful transitioning was contingent upon modifying weight to conform to gender norms:

If someone says [they] want to appear more feminine, […] if […] they consider themselves overweight, that will include losing weight. […] Whereas […] if someone's transitioning into masculinizing therapy, then weight isn't usually brought up […] though, sometimes […] they want to go to the gym, […] have the muscle mass, […] and that more quote, unquote, masculine appearance. (1014)

Similarly, a gay dietician critiqued the misogyny and sizeism embedded in gay male culture, reflected in a pervasive “anti-femininity discourse […] ‘no fats, no femmes’” (1002). He explained how the exclusion of undesirable bodies tended to be condoned under the guise of “just [being] a personal preference” (1002), thereby obscuring the interlocking systems of oppression and privilege.
Approximately half of the patients highlighted that weight stigma was underpinned by other oppressive systems. One Metis patient’s account alludes to practitioners’ reliance on individualistic and biologically deterministic discourses, particularly the geneticization of race in relation to obesity:

I come from a family of Metis. […] We've always been treated […] not very well in the health care system […], which is you're obese, you gotta lose weight. […] We know your family history, you’re […] Metis […], you’re genetically coded to doing that. (2008)

A White patient similarly underscored the historical role of White supremacy in perpetuating weight stigma. Citing Strings (2019), a sociologist whose work traces the racial origins of fat phobia, the patient elucidated how Black people had been positioned as the savage Other, incapable of disciplining their unruly bodies: “The weight ideal was […] we want to be the opposite of those Black people who […] have bigger bodies and are shaped differently. We want to be refined, and White and small bodied” (2004). Another White patient pointed out that standards of beauty and weight were racialized, denouncing how the “body acceptance movement […] was […] co-opted by White folk” (2002). In her view, body acceptance as portrayed in mainstream media still involved White-dictated beauty norms:

[…] There’s certain things that White people take of other people’s bodies, and then all of a sudden they make it cool again, […] having like a huge butt, having huge lips, having huge breasts […] But then […] we discriminate against people who […] naturally have those things […]. (2002)

Slightly under half of the practitioners’ and half of the patients’ characterizations of intersectionality seemed reminiscent of the additive model that considers the accruing effects of discrete oppressions. When prompted to reflect on the linkage between weight discrimination
and other oppressions, one doctor mentioned that being multiply marginalized exacerbated suffering for people: “I think [different kinds of discrimination are] all potentially hurtful. […] hurtful is health reducing, [it] can reduce people’s incentive or […] ability to move forward with their own challenges” (1021). Another patient’s description of the oppression she faced evoked the additive model of intersectionality, in which distinct aspects of one’s identity increased one’s likelihood of being targeted, and collectively impacted one’s everyday experiences:

[…] The marginalization […], it adds upon it, like kind of compounds [emphasis added] with each other. So it almost gets to the point where it's like, […] was I just mistreated because I'm fat or queer or Asian? […] You have […] so many more things that you can kind of choose upon. (2007)

A couple of patients and practitioners spoke of different oppressions as similar, which also reflects the additive model that examines and compares distinct oppressions, yet pays less attention to how these systems secure one another. One doctor adopted this approach to weight stigma:

It is the equivalent [emphasis added] of systemic racism towards a medical condition […]. That's identical [emphasis added] to systemic racism […] It's like a form of bigotry towards an identifiable, marginalized group that deserves to be treated with dignity and respect. (1021)

Another patient emphasized the commonality amongst all prejudices, explaining that they were all rooted in the shunning of those who deviate from the perceived norm:
[...] All prejudices stem from the same place in the [...] reptilian brain. [...] Any slight diversion such as skin tone, [...] size, weight would instantly identify the stranger as a potential, serious threat. (2009)

6.4.4 Straddling the Line Between Equity and Equality.

Participants’ accounts revealed that healthcare often involved straddling the line between equity and equality. Most practitioners recognized that not everyone began on an equal footing, and stressed that larger patients had unique needs. A dietician asserted that equitable care for larger patients meant treating them where they were at rather than putting their care on hold until they lost weight:

I don’t think it’s necessarily about quote unquote seeing past their weight [...] This person is in a larger body and they are going to have different needs [...] It’s seeing past this idea of [...] having to lose weight in order to have their needs met. (1003)

Another dietician expressed that equity involved operating from an understanding of the long-lasting effects of trauma on patients’ lived experiences:

[I] just kind of [go] into sessions assuming that a person's already experienced weight-based discrimination. [...] I think being extra sensitive [...] taking the time to build rapport is number one, which [...] isn’t necessarily just about larger bodies, but people who have experienced discrimination or trauma. (1016)

Over half of the patients highlighted the need for equity, as articulated by one patient:

It's not just giving the same treatment to every single person, it's customizing the way that you're supporting them so that [...] their actual needs are being met [...] [Healthcare practitioners] wouldn't just blanket serve someone, they would say [...] you know, in your culture, are you comfortable with these medications? (2020)
For another White patient, an understanding of equity was shaped by an awareness of her own racial privilege. She contended that the misguided notion of equality around race failed to account for historical and systemic racism:

> People have disadvantages automatically because of [...] whatever the factor is, and [...] [...] people of color [...] generally have fewer advantages than White people [...]. If you treat everybody the same, you ignore the fact [...] that people of colour started behind White people just because of the colour of their skin and [...] their culture. And so [...] when you talk about justice, the root word is just, it's not just to treat everybody the same.

(2001)

However, the discourse of equality seemingly still held power for participants, both as a casual word choice and on a deeper ideological level. When asked to reflect on their understanding of social justice, approximately a quarter of patients and a couple of practitioners brought up the notion that everyone should be treated the same. One patient touched on the idea of universal human needs to explain equality:

> If you have someone that comes in [...] and they're a drug addict, there's still a human being, you know, [...] we are all just people [...] we all have a need for care, [...] empathy, and love [...] and trying to provide that no matter what. (2006)

Similarly, a dietician espoused the notion of equal care for all patients: “I give everyone the same care and compassion [...] so I don't distinguish between them” (1006).

> Though the term equality was commonly used, it did not entirely represent participants’ values around patient care. When prompted to consider the differences between equal and equitable care, almost all patients and practitioners who mentioned equality acknowledged its limitations and expanded on their initial definitions. One General Practitioner who first spoke
about equal treatment later explained that equity was important, though not always a top-of-mind priority: “we're not always thinking about [social challenges] so we don't always offer equitable care to everybody […]” (1014). A dietician suggested that practicing equity was hindered by the systemic barriers seemingly beyond her reach:

There are so many issues that people can present with sometimes and it's very tricky […] to navigate all those rounds […] But […] what I can do is […] direct them or maybe do some of that work myself, look into resources that can help them in certain ways like meal services […] and […] making referrals where appropriate. (1001)

6.5 Discussion

We have outlined four themes related to structural competency and critical consciousness: an awareness of how one’s concurrent experiences of marginalization and privilege impacted the healthcare interaction; navigating between additive and interactive approaches to understanding intersectionality; integrating micro and macro approaches to change; and straddling the line between equity and equality. To explore participants’ social identities, we reported the ways they stressed different affiliations with social categories (Christensen & Jensen, 2012). In line with a social justice framework, we explicitly probed into structural issues such as sizeism, racism, and sexism, and the ways in which they intersected, rather than adopting the dominant epidemiological approach of studying difference through demographic questions alone (e.g., what is your gender?). Within the patient-clinician dyad, clinicians held more relational power, and they prioritized humility and learning from patients, rather than pursuing an end-point of mastery (Tervalon & Murray-García, 1998). Practitioners in the study who had experienced discrimination, including weight stigma, conveyed that such experiences fostered empathy towards larger patients’ struggles. This finding supports prior
research indicating that practitioners with a higher BMI (Swift et al., 2013), friends with obesity, and an understanding of obesity were less likely to display weight bias (Schwartz et al., 2003). Furthermore, Swift et al. (2013) suggest that higher weight practitioners may be more attuned to the complexity of weight and less inclined to display “attitudes motivated by ego-defensive functions (i.e. attitudes that protect our self-concepts by maintaining a superiority over others)” (p. 399). Unlike research (Puhl et al., 2013) demonstrating that larger bodied doctors were seen as less credible and trustworthy by patients across different body weights, half of the patients in this study found such practitioners to be more relatable. While past research (Zhu et al., 2011) suggests that larger bodied practitioners were less confident in their weight management practices, practitioners in the present study mostly viewed their own embodied experiences with weight as a strength that allowed them to enhance connections with patients. At the same time, our study findings demonstrate that the cultivation of empathy and the desire to take action amongst clinicians were not dependent solely on having the same identity-based experiences as patients, and were instead rooted in a broad-based awareness of power relations and social inequities.

When describing the intersectional nature of oppressions, participants were divided between additive or mutually constitutive approaches. We acknowledge that participants’ accounts represent a snapshot of their perspective and do not necessarily suggest that they exclusively subscribe to one model. Nevertheless, these divergences highlight the need for greater conceptual clarification and critical dialogue on the various understandings of intersectionality and how weight stigma is tackled in healthcare settings. Our findings are reflective of the broader tensions within intersectionality scholarship, which tends to be polarized between the inseparability and separability of categories (see McCall, 2005 for an overview of
the anti-categorical, inter-categorical, and intra-categorical approaches to intersectionality). However, Gunnarsson (2017) has argued that rather than succumb to either/or thinking, we can understand intersectional categories as *both* distinct and unified. If we understand one category to have effects that are irreducible to the effects of other entities, we can conceive of it as having a distinct reality that is nevertheless shaped by relations with other categories (Gunnarsson, 2017). Thus, we can put the spotlight on one particular dimension such as race or weight as a focal point of analysis to represent its salience in a specific geohistorical context (Gunnarsson, 2017). Even so, we must refrain from rigidly separating social categories in a way that forecloses understandings of how systems of oppression rely on one another for their reproduction (Fellows & Razack, 1998). Most of the existing clinical studies on weight tend to obscure the complexity of social reality, typically only including race as a control variable that is not of interest to the study’s aims. Even when racial differences are studied, obesity is often presented as a taken-for-granted reality that lower income and non-dominant racial groups suffer from (see Himmelstein et al., 2017). Race is thus seen as either compounding or buffering the effects of weight stigma (see Bucchianeri et al., 2013). Yet other researchers have isolated the independent effects of racism on weight gain, seeking to control variables such as weight stigma “to reduce the chance of spurious findings” (Gee et al., 2008, p. 293). In both popular media (see Feder, 2019) and the research literature (see Puhl, et al., 2008a), weight stigma has been compared to other oppressions and proclaimed to be the last socially acceptable form of prejudice. These narratives reflect the additive model, which typically emerges from the positivist, quantitative tradition that stabilizes each social category for systematic analysis. This approach can be an important *starting point* for social justice dialogue as it makes visible the distinct effects of each oppression and directs our attention to domains requiring intervention. However, the danger of relying
exclusively on the additive model is that issues such as fat phobia and racism are presented *only* as equivalent oppressions, without uncovering how fat phobia has its roots in racism, sexism, classism, and the policing of unruly bodies (Strings, 2019). Thus, in healthcare settings where the intertwined nature of oppressions has historically been overlooked, it is important to strategically emphasize the role of co-constitution. Patients’ experiences of fat phobia must be understood within the context of colonialist tropes labelling Indigenous and non-dominant racial populations as regressive and uncivilized (McPhail, 2017). Improving the quality of care for marginalized communities requires us to extend our notions of health beyond dominant Eurocentric ideologies and dismantle weight stigma not as a standalone issue, but alongside its interlocking systems of oppression.

Participants’ accounts of grappling with micro and macro approaches reflect an ongoing, contentious debate in social theory: the role of structure versus agency in individuals’ daily realities (Lupton, 2013). For participants, integrating social justice into clinical practice meant understanding individual health behaviours related to weight and otherwise as bounded by broader social conditions, while recognizing that people had situated agency to improve their wellbeing in the face of external challenges. These findings align with prior research by Malatzky and Glenister (2019), who found that GP participants eschewed dominant individualistic approaches to weight. Unfortunately, research shows that the personal responsibility for health discourse still exerts power on larger patients, who experience self-blame because of their weight status (Lewis et al., 2011; Thomas et al., 2008). Studies indicate that larger individuals tend to hold themselves culpable even though they are acutely aware of the complexities of trying to regulate their bodies, and acknowledge various socio-cultural barriers and influences (Kirk et al., 2014; Pausé, 2014). Most patients in this study did not
engage in self-blaming attitudes; instead, they emphasized the multi-factorial determinants of weight and health beyond their immediate locus of control, even as they strived to make lifestyle changes.

An ideological tension between practicing equity and equality in healthcare appeared in participants’ perspectives, which corresponds with Valderama-Wallace and Apesoa-Varano’s (2019) study on nurse educators’ understandings of social justice. The researchers found that a White racial identity strongly predicted viewing social justice as equality. Other research indicates that White clinicians were more likely to embrace a colour-blind ideology associated with equality, and attribute racial disparities in healthcare to individual shortcomings rather than systemic discrimination (Malat et al., 2010). In contrast, participants in the present study vacillated between the two ideologies of equality and equity, and no clear racial patterns in their conceptualizations were identified. Equality, when invoked by participants, was used to highlight universal baseline human needs, such as respect and compassion. Nevertheless, as Manning (2019) contends:

>The idea that all humans share the same needs can be used, tragically, to obscure the reality that some people, based solely on group membership, have certain needs go unmet to a greater extent, for a greater length of time, and with more dire consequences than others. (para 5)

Despite the powerful ideology of equality, participants did not use it in an absolute way and augmented their initial definitions to incorporate equity, suggesting that they recognized the need to redress deeply entrenched social injustices in healthcare and other institutions.

The present study is limited in that patients of only some participating clinicians were able to be recruited. Some clinicians, particularly doctors, were located in provinces outside of
British Columbia, where ethics approval could not be granted for the recruitment of their patients. As such, these clinicians’ accounts were not able to be critically compared against other sources, namely patients’ perspectives. Future research that draws on multiple methods such as observation, documents, and interviews with various healthcare stakeholders could shed more light on the clinician-patient dyad.

6.6 Conclusion

Our findings provide a framework for integrating social justice into weight-related clinical interactions, while situating weight stigma within the broader context of social inequities. The transformative potential of this framework lies in its ability to unmask the “often invisible determinants, biases, inequities, and blind spots that shape health and illness long before [clinicians] or patients enter examination rooms” (Metzl & Hansen, 2014, p. 127). It also encourages practitioners to recognize that health behaviors and choices are not isolated events shaped by the absence or presence of knowledge possessed by the individual, and are instead circumscribed by one’s life conditions within the systems of dominant culture (Kelly & Barker, 2016). A social justice approach is tempered by the humble recognition that clinicians alone will not be able to rectify structural inequities and that healthcare interventions will always be partial solutions to illness and suffering (Downey & Gómez, 2018).

This study makes a unique contribution to the literature in featuring practitioners who self-identified as having a social justice approach to weight, as well as larger patients who received social justice-informed care. The synergies in participants’ perspectives across certain social identities suggest that the cultivation of social justice awareness potentially mitigates some of the blinders of privilege. Furthermore, practitioners’ social justice orientation positively impacted patient experience, with the majority of patients expressing appreciation for having
their various histories of trauma and social challenges handled compassionately during the appointment. While our study has sought to offer an alternative to the dominant individualistic approach to treating obesity, the findings are relevant to practitioners addressing a range of health issues rooted in social injustices within clinical settings. As our participants’ accounts suggest, providing equitable care to larger patients requires not only an attention to weight stigma, but a nuanced understanding of how weight stigma is constituted by interlocking systems of power and oppression, such as colonialism, racism, sexism, and heteronormativity. Promoting social justice and health equity is ultimately contingent upon a commitment to dismantling not just one system but all the other interlocking systems (Fellows & Razack, 1998).
Chapter 7: Article 3: Integrating Person-Centered Care and Social Justice: A Model for Practice with Larger Bodied Patients

7.1 Introduction

Person-centred care (PCC) has been touted as a promising paradigm for improving patients’ experiences and outcomes, and the overall therapeutic environment (Kalra et al., 2020; Wakefield & Feo, 2017). PCC focuses on the whole person rather than just their medical conditions, and its related principle, person-directed care, positions the individual to lead care-based decisions (Lines et al., 2015). Within this framework, clinicians move beyond the traditional biomedical approach, attending to not only a person’s medical diagnoses and physical measurements, but also their social, psychological, and emotional needs, as well as their strengths, weaknesses, and values (Lines et al., 2015). This approach represents an important shift away from a paternalistic, disease-focused, and traditional top-down paradigm in which power and authority are placed largely in the hands of health professionals (Franklin et al., 2021). However, PCC runs the risk of reinforcing neoliberal individualistic approaches to care in which the management of health conditions is shifted away from collective responsibility towards the individual patient, amplifying moralistic judgment of patients who do not adhere to health directives (Lewis et al., 2022). As a counter to the increasing individualization of healthcare, we suggest that PCC must be explicitly “reconfigured within a social justice […] framework” (Pulvirenti et al. 2011, p. 303) to achieve optimal conditions for health and well-

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4 As noted on p.vi, this chapter has been submitted to Medical Humanities for review, and feedback has been received from the reviewers. The third round of revisions have been completed and the manuscript was re-submitted on September 22, 2022. Please note that references have been removed from the end of the manuscript and amalgamated into the references section at the end of the dissertation.
being. We define the concept of social justice as the distribution of goods, services, opportunities, and rights within a societal context that allows all individuals to maximize their capacities (Russell-Mayhew, 2006). This framework allows individuals to have self-determination over their own bodies and lives, while understanding self-determination as a fundamentally social process that is engendered by supportive relationships and environments (Raines, 1989). We distinguish the concept of self-determination from the discourse of individualism, in that the former enables the person to narrate their strengths and their understandings of health, whereas the latter compels the individual to strive towards a narrowly defined ideal of health. The transformative social justice potential of PCC lies in shifting the practitioner-patient power dynamic, as well as in addressing the intersecting social determinants of health, such as income, social support, education, and discrimination. Such an approach is particularly important for centering the voices of historically marginalized groups who face challenges in accessing care and getting health needs met (Drury & Louis, 2002; Wilson & Neville, 2008).

PCC has been applied as a framework to study a range of medicalized conditions, including diabetes (Boström et al., 2014), dementia (Kim & Park, 2017), cancer (Pel et al., 2021), and obesity (Kalra et al., 2020). While understanding patients’ values, knowledge, and preferences has been embraced in theory, it is often less clear what should be done in practice when patients’ values and preferences diverge from practitioners’ (Carey, 2016; Franklin et al., 2021). Research suggests that even practitioners who claimed to be person-centred reported taking on the role of ‘expert’ and “privileging their professional knowledge over patient knowledge” (Franklin et al., 2021, p. 345). Carey (2016), in his critique of the current model of PCC for mental health, notes that improving patient compliance – often cited as a key benefit of
PCC - appears to be fundamentally incongruent with the core tenet of patient self-determination. This notion of compliance, also referred to as adherence, has been discussed in relation to obesity to describe patients’ ability to maintain health behaviours such as exercise and weight loss (Shay 2008). While PCC is presented as the solution to countering pervasive weight stigma and discrimination in healthcare (see Cardel et al., 2022), the goals of weight management and loss may still be promoted. This model of care places the power of diagnosis in the hands of so-called obesity experts and obscures the voices of larger patients who do not desire medical intervention on their weight. We contend that a social justice informed approach to PCC in the context of working with larger individuals must seek to facilitate a safe environment where individuals can leverage their strengths to direct their own healing journeys – which may or may not include weight management.

In the following sections, we begin by outlining the value of integrating PCC with social justice. We then demonstrate how the existing studies on PCC for obesity seek to combat weight stigma in healthcare settings, but only go so far in achieving social justice goals as they operate within a biomedical model that pathologizes excess weight and pre-determines patients’ goals. There remains a dearth of empirical research on what social justice-informed PCC looks like in practice with larger patients. This study fills a research gap by exploring the perspectives, experiences, and relational dynamics of 1) health practitioners who take a critical, social justice-informed approach to weight and 2) patients served by such practitioners. The research questions that informed this paper were: What are the characteristics of social justice-informed PCC that play out in clinical interactions between healthcare practitioners and larger bodied patients? How does this approach to care impact larger patients’ experiences?
7.2 Integrating PCC and Social Justice

The integration of PCC and social justice presents a potentially powerful framework for addressing a range of health issues. This framework understands individual health behaviours as circumscribed by the broader context (Pulvirenti et al., 2014) and recognizes that individuals have self-determination and situated agency to direct changes in their life conditions (Gkioulekaa et al., 2018). The concept of situated agency emphasizes interconnectedness, departing from individualistic accounts of the self as divorced from its economic, political, social, cultural, and environmental contexts (Bevir, 2017). Research on patient-practitioner interactions in relation to chronic disease management illustrates the pernicious effects of the discourse of individualism: patients who were unable to successfully self-manage were deemed as moral failures, thereby undermining the therapeutic relationship (Lewis et al., 2022). Mol (2008) proposes a relational logic of care as a contrast to the pervasive logic of choice: Good care goes beyond patients’ individual choices, and requires clinicians’ collective efforts to interweave technical expertise, critical consciousness, and compassion to create safe environments for patients. Within such environments, patients can leverage their strengths to direct their own healing journeys, which for larger patients may or may not include weight management. Ultimately, patients’ capacities for self-determination can only be optimized if “society at large, healthcare policy, healthcare infrastructures and health care professionals alike […] both reflect and promote this orientation” (McWilliam, 2009, p. 284).

PCC challenges the traditional model of clinician-patient communication, premised on the assumption that patients and clinicians necessarily have the same beliefs and values towards medical information, and that such information will be regarded by patients as a resource to
acquire (Frank, 2002; Kennedy et al., 2017). Frank (2002) argues that this misguided assumption is what underpins “the conflict between the story [that the patient] is caught up in and the story that medicine tries to impose on [them]” (Frank, 2002, p. 19). PCC seeks to resolve this conflict by cultivating practitioners’ narrative competence, defined as the ability to elicit, acknowledge, comprehend, and act on patients’ stories (Charon, 2001). It allows practitioners to attend to how beliefs and values arising from social and behavioural factors shape the clinician-patient interaction (Ha & Longnecker, 2010). Some patient beliefs and values include a preference for alternative therapies and a distrust of the healthcare system and prescribed therapies (Ha & Longnecker, 2010). To demonstrate narrative competence, clinicians can ask questions beyond patients’ presenting health conditions to uncover other underlying issues in their social contexts (Kalitzkus & Matthiessen, 2009). More unstructured and unpredictable than traditional medical history taking, this approach asks open-ended questions like “would you like to tell me why you came here?”, “what would you like to return to?”, and “what are your goals?” (Naldemirci et al., 2020, p. 239). Although time constraints and other barriers may limit clinicians’ abilities to fully delve into patients’ stories, clinicians can briefly scan patients’ records in advance to maximize time spent with patients, avoid repeating questions, and help themselves “[imagine] and [predict] the social, personal story of the patient” (Naldemirci, 2020, p. 242).

Another essential component of PCC is interprofessional collaboration (IPC), which is based on the understanding that patients’ complex needs require collaborative efforts across professions and coordination with community stakeholders (Hines-Martin & Nash, 2017). IPC can take different forms, such as organizing healthcare practitioners into teams or coordinating and networking efforts (Oelke et al., 2013). Referrals to other professionals is an important first step in building relationships and sharing patient-related information to meet patients’ needs.
Referrals may not necessarily lead to collaboration, but they nonetheless offer opportunities for continuity in the delivery of care (Aboueid et al., 2018). Although interprofessional practice is widely regarded as an ideal to strive towards, its implementation is undermined by some key barriers: Territoriality, mistrust, perceived lack of respect, and power differentials (McDonald et al., 2012; Oelke et al., 2013). Research on IPC shows that within the hierarchy of healthcare, doctors are still regarded as the experts and attempt to protect their professional autonomy and independence in their relationships with other practitioners (McDonald et al., 2012). Power differentials in healthcare settings are often understood implicitly but not confronted head on, leading to unresolved tensions and conflicts (Oelke et al., 2013). Nevertheless, these issues can be mitigated by conducting training activities for different professionals to engage in self-reflection and dialogue, thereby gaining a deeper understanding of one another’s roles and working styles (McDonald et al., 2012).

7.3 PCC and Alternatives to the Dominant Model of Obesity Treatment

Weight stigma is widespread in healthcare settings, evident in how many health practitioners blame and shame heavier patients for their weight, undermining patient dignity and quality of life (Phelan et al., 2014). Practitioners who hold such prejudicial attitudes tend to attribute obesity to a lack of personal control and conflate weight management with moral worth, revealing an individualistic ideology that places responsibility for health solely within the hands of patients (LeBesco, 2011; Nutter et al., 2016). The dominant model of obesity treatment within biomedicine and public health has tended to focus on individual-level factors such as a person’s genetics and lifestyle choices (Saguy, 2013). Many clinicians subscribe to the energy deficit or calorie model, which focuses on controlling food intake and exercise for weight management (Schaefer & Magnuson, 2014). However, this approach to treating obesity has been found to
have detrimental outcomes for larger patients, including increased psychological distress and disordered eating patterns (ScHaefer & Magnuson, 2014). In light of these concerns, numerous studies have explored how PCC can be used to improve the quality and success of obesity treatment (Kalra et al., 2020; Leske et al., 2012). These studies define PCC in varying ways, though common themes include treating patients with compassion and respect, including patients in shared decision-making, allowing patients to take ownership of goals, and listening to patients’ health narratives. Other studies have examined how IPC can improve clinical outcomes for obesity by fostering an exchange of knowledge on weight management amongst physicians, dieticians, psychologists, nurses, and physical therapists, amongst others (see Aboueid et al., 2018; Ward et al., 2018). Collectively, the research on PCC for obesity suggests that individuals are empowered to resolve their ambivalence around lifestyle behaviour change and seek medical help for obesity (see Kyle et al., 2018). However, these studies (see Leske et al., 2012) foreground weight management as the goal and label larger people as sick, irrespective of patients’ overall health status and desire to lose weight, and are thus incompatible with social justice goals (Saarni et al., 2011).

Another proposed counter to the dominant model is the Health at Every Size (HAES) or weight-inclusive approach, which shifts the focus away from weight towards enhancing health, regardless of where individuals fall on the weight spectrum (Aphramor & Gingras, 2011; Burgard, 2009; Rich et al., 2011). HAES promotes the adoption of a healthy lifestyle including exercise, nutrition, and sleep, and recommends that indicators of health beyond BMI and body weight be established (Rich et al., 2011). HAES is a fluid movement taking multiple directions, and some configurations of HAES have been criticized for their individualistic emphasis on lifestyle factors and for positioning health - rather than weight - as a moral imperative (Gingras
& Cooper, 2012; Lupton, 2013). Other strands of HAES explicitly adopt a social justice lens that locates individual choices and behaviours within broader social and economic inequities (see Burgard, 2009 for a counter-response to critiques of HAES). Although the HAES model has been extensively explored in the theoretical literature and intervention studies measuring clinical outcomes (see Bacon et al., 2005; Steinhardt et al., 1999), there remains a lack of qualitative research on how this lens shapes the patient-practitioner relationship and interaction. A smaller body of literature has examined practitioners’ beliefs and attitudes towards alternatives to weight loss counselling such as HAES and intuitive eating practices (Barr et al., 2004; Schaefer & Zullo, 2016; Willer et al., 2019). Willer et al. (2019) found that HAES is a “familiar and accepted (though somewhat misunderstood) practice” (p. 412) amongst Australian dieticians, some of whom were misguidedly using this approach for the purpose of weight management. While these studies pave the way to subverting the dominant paradigm of obesity treatment, they tend to focus on HAES principles of non-dieting and body acceptance, paying less attention to how weight stigma is entangled in other systemic inequities such as racism and colonialism (Guthman & DuPuis, 2006; Strings, 2019).

We contend that a social justice-informed approach to PCC for larger patients must not only center their perspectives but connect individual agency with the broader social context. Furthermore, weight stigma should not be tackled as an isolated issue but located within other systems of oppressions that patients are immersed in. This theoretical framework of integrating social justice and PCC that we adopt will guide our research methods, which we outline in the following section.
7.4 Methodology

7.4.1 Language, Labels, and Reflexivity

We adopt the stance that researcher reflexivity is not inherently radical nor transformative (Lynch, 2000), as “we do not escape from the consequences of our positions by talking about them endlessly” (Patai, 1994, 70). Nevertheless, we do not believe that the solution is to give up on reflexivity, but rather, to use our positionalities in ways that encourage open discourse and awareness-raising (Pillow, 2003). As part of the first author’s larger PhD study, she engaged in reflexive writing, examining how her social identity and background had shaped her values and beliefs, including her choice of research topic and approach to data collection and analysis. She also engaged in regular reflexive dialogue with her PhD supervisors, who are this paper’s co-authors, to explore feelings and thoughts that emerged during her interactions with participants. During the entire research process, a key issue that came to light was the nuances and tensions in participants’ perspectives on obesity and its associated language, which echoes what has been found in the literature.

Within these linguistic and ideological debates, the dominant biomedical model considers excess weight to be a health problem warranting intervention, and uses the terms ‘obese’ and ‘overweight’ to describe bodies that deviate from weight normative standards (Campbell, 2021). Conversely, critical fat/weight scholars reject such biomedical language, which they regard as pathologizing and stigmatizing larger people (Burgard et al., 2009; Cooper, 2010). Some of these scholars connect anti-fat discourse with other systems of oppression, such as White supremacy, classism, and patriarchy; they also seek to reclaim historically denigrated terms such as ‘fat’ in order to diminish their negative power (Guthman & DuPuis, 2006; Strings, 2019). Nevertheless, reclaiming language is a fraught process, as evident in how patients displayed contesting
preferences around weight-related terminology (Volger et al., 2012; Ward et al., 2009). Aligning with a PCC approach, we asked patients to self-identify with descriptors during the interview process. In this article, we have decided to use the term ‘larger-bodied’ to capture patients’ collective experiences. While we strive to be allies in fat acceptance, we are not self-identified fat people and thus do not use fat as an identity descriptor. In light of fat’s politically contentious underpinnings, we believe that the decision should lie with the individual to self-identify as such. When using the term fat, we refer to participants’ own descriptions of their bodies and identities. We use the term obesity to represent the divergent discourses around the phenomenon, which comprise both dominant biomedical and critical fat/weight approaches.

### 7.4.2 Data collection: Interviews

The data presented here are part of the first author’s doctoral study featuring qualitative one-on-one, in-depth, and semi-structured interviews with 22 healthcare practitioners and 20 of their patients. Each interview lasted between 45 minutes to 1.5 hours and was conducted over the phone or Zoom, enabling the recruitment of participants from different Canadian provinces. The doctoral study featured exemplary social justice-oriented practitioners and patients who have benefitted from their care, in order to examine how social justice is understood, enacted, and experienced in weight-related clinical interventions. An interview guide for the study was designed around four overarching questions pertaining to interactions between practitioners and larger patients: 1) What does social justice mean to practitioners and patients? 2) How do practitioners translate principles of social justice into concrete practices and behaviours when interacting with larger patients? 3) What are the challenges of practicing social justice that practitioners encounter when working with larger patients? 4) How does social justice-informed care impact larger patients’ experience? Both practitioners and patients were asked about their
definitions of social justice in practice, the nature of patients’ involvement in healthcare
decisions, the manner in which patients’ social challenges were identified and addressed, and
how they dealt with experiencing and/or witnessing weight-stigma in healthcare. Practitioners
were also asked about their views on weight management practices, and patients were asked
about whether they felt their weight impacted their health, and what they appreciated most about
the care they received from practitioners. Since interviews took a semi-structured format, follow-
up and clarifying questions were determined according to what participants revealed and
highlighted during the discussion.

A combination of methods was used for recruitment, beginning with purposive sampling
of practitioners. To start, the first author reached out by email to healthcare professionals in
Canada who in their public profiles self-identified as advocates of social justice and/or weight-
inclusive approaches that encompassed a variety of terminologies such as HAES and intuitive
eating. Practitioners were provided with sample interview questions exploring social justice in
healthcare practice to determine if they would be a good fit for the study. Those who confirmed
that they were able to speak to social justice practices and had experiences interacting with larger
patients were then included in the study. Next, the first author drew on the healthcare practitioner
liaison approach, which refers to leveraging personal contact from a fellow healthcare
practitioner to recruit participants (Asch et al., 2000). Her PhD committee member, a physician-
activist, served as the key liaison point. Finally, using snowball sampling, shortlisted candidates
were asked to refer other relevant practitioners. Given that this paper was part of a broader PhD
study that explored the intersections amongst weight stigma and other oppressions, where
possible clinicians of colour and those serving marginalized communities including low-income
and non-dominant racial groups were targeted. Clinicians who agreed to participate then assisted
with recruitment of their patients by disseminating flyers at their clinics or e-flyers via their patient electronic mailing lists. The flyers outlined the study and invited patients who self-identified as being larger bodied, fat, overweight or living with obesity to participate. This approach of self-identification of bodily experience is aligned with PCC and critical fat/weight studies which avoid BMI as an inclusion criterion (Bombak et al., 2016). All 20 patients who participated were recruited from 6 out of the 22 practitioners in the study; the remaining practitioners could not recruit their patients either because of recruitment restrictions or a lack of patient interest. Patients were seeing practitioners for a variety of reasons including weight management, coping with weight stigma, and/or for general medical appointments. As an equity measure for historically disenfranchised communities (Collins et al., 2017), each patient received $50 remuneration for participation. The university institutional review board approved the study, and all participants provided written informed consent. Participants were assigned numeric identifiers (10XX for practitioners and 20XX for patients) to retain confidentiality. Figure 1 indicates the breakdown of participants’ demographics. The majority of the practitioners were Registered Dieticians (RD), female, and White, and the majority of the patients were female and White, and were seen by Medical Doctors (MD).

7.4.3 Patient and Public Involvement

Patients and the public were not involved in the design of the study.

Figure 1.
7.4.4 Data Analysis

The first author transcribed the interviews verbatim and examined the interview material using the method of critical thematic analysis (Lawless & Chen, 2019), which is compatible with a PCC and social justice framework that seeks to uncover critically-informed themes of power hierarchies and social inequities in interview discourses. The data analysis process integrated both deduction and induction, but began deductively with theory (Smith & Elger, 2014). A deductive coding scheme was developed a priori based on the theoretical framework of social justice informed PCC, the literature review, and research question, all of which were broadly focused on thematic categories of the social determinants of health, weight-based discrimination, patient self-determination, narrative competence, interprofessional collaboration, and community linkages. Next, the first author developed preliminary themes, applied them to a few transcripts, and assigned codes to their corresponding themes. Through this process, the original themes and codes were refined, combined, and re-organized. Drawing on the established comprehensive code manual, the process was repeated with both the initial and remaining transcripts. Inductive coding was concurrently used to examine the repetition, recurrence, and forcefulness of themes.
that had not been initially listed but were nevertheless connected with the broad thematic categories (Owen, 1984). To enhance rigor, the first author’s two PhD supervisors and co-authors independently reviewed and critiqued the preliminary themes and findings.

7.5 Findings

In the following section, we discuss five themes, with each theme reflecting the perspectives of both practitioners and patients. These themes include: 1) the need to integrate evidence-based practice with compassionate care; 2) the value of practitioners taking a curious attitude about the patient’s world; 3) centering patients’ own wisdom about their conditions; 4) advocacy for patients to receive equitable care; and 5) the benefits of interprofessional collaborations and community linkages.

7.5.1 The Need to Integrate Evidence-based Practice with Compassionate Care:

This is Not a “Fluffy Approach” (Practitioner)

All practitioners conveyed that narrative-based skills such as active listening and compassionate witnessing were essential components of clinical practice that had to be brought to the forefront of the patient-practitioner interaction, particularly with marginalized patients who had been repeatedly disappointed by the system. A dietician called attention to how evidence-based practice (EBP) and its associated principle of scientific objectivity tended to be privileged over a narrative approach that explored the individual stories of patients. Noting that practitioners often had their “science blinders” (1002) on, he contended that “the biggest challenge arising from that is [practitioners] don’t have good people skills and […] need to […] work on that […] so that [they] can talk to people about their lives and how their lives are impacting their health” (1002).
Similarly, a doctor pointed out that compassionate communication was crucial with patients who were “outside of the norms, whether it's with weight or […] colour, or […] other issues” and who had already experienced “lot of communication that [was] hurtful” (1021). He cautioned against the lack of “helpful healing communication […]” with patients:

Patients will come away from interactions that have been hurtful with the idea, well, who cares? Why should I care? […] I'm not worth it. [Patients] will […] do things that further reduce their health as opposed to being inspired to do things that improve their health and happiness. (1021)

As a dietician professed, even though this approach to care was “often seen as […]a…] fluffy approach […] as a clinician”, it was ultimately what “makes or breaks the deal” (1016).

Correspondingly, patients’ narratives overwhelmingly demonstrated the need for practitioners to integrate scientific knowledge with compassion. One patient alluded to how knowledge itself was a contested terrain, evident in the range of conflicting evidence around obesity and weight management. As such, she viewed knowledge alone as insufficient to guide the clinical encounter, and highlighted the need for clinicians to display compassion when discussing scientific evidence:

The knowledge part can be tricky because if you want to believe a certain thing, you can find research to back that up. […] If you've got a patient who is reading different things […] a health care practitioner […] needs to have compassion to meet me where I'm at in my journey. (2001)

Another patient concurred that compassion and knowledge were intertwined, as practitioners who were well-read on issues of weight stigma and its intersecting inequities were able to display greater awareness of patients’ struggles:
My dietitian was the first one to introduce to me [the notion of racism and weight stigma being intertwined…] Anytime we talked about [it] and she lends a compassionate ear, I find this very impactful because she's […] reinforcing what I know [and] that's very healing. […] A lot of the […] things I've read about, she has read about too. […] There's an exchange of knowledge around […] the issue […]. (2004)

Conversely, a patient pointed to how the lack of knowledge could detract from compassion. Describing her mother’s doctor (not featured in the study), the patient remarked: “her doctor […] believes that the compassionate thing to do is to try to motivate her to not eat doughnuts, except that it's not working.” (2001). The patient noted that such an approach had the unintended consequence of exacerbating her mother’s shame, and emphasized that she wanted to see more doctors familiarize themselves with the “research [on weight-neutrality] that says […] maybe it's not possible to actually lose weight […] in a sustainable way” (2001). Ultimately, doctors who did not understand the complexity of weight could have a well-intentioned, but misguided approach to caring for the patient.

7.5.2 The Value of Practitioners Taking a Curious Attitude about the Patient’s World: “I'd Rather They Ask a lot of Questions” (Patient)

All practitioners underscored the importance of displaying inquisitiveness about patients’ lives beyond their presenting medical issues and asking difficult questions about their social context, including experiences of discrimination and barriers to care. A social worker contended that body size needed to be recognized as a social justice issue to counter the prevailing choice narrative: “[There’s an idea] that people are choosing to make bad choices about food and […] exercise. And that it's all about […] individual behaviors rather than wider determinants” (1007). A General Practitioner echoed: “When a person has a problem it's almost always from their
social environmental situation. [...] I'm quite comfortable asking because I think that's where the meat is” (1022). He went on to say: “One of the challenges is to make sure that the patient actually feels you're comfortable with the answer. [...] You want to make sure that in a negative answer [...] there's room for it” (1022). Some questions that practitioners asked included “What is going on in your life? [...] Are you stressed out because of finances?” (Dietician, 1008).

Another General Practitioner noted that initiating lines of inquiry fostered a sense of emotional safety for patients:

A lot of people suffer things and [...] don't tell us [...] They... have been burned by [...] not being able to have conversations [...] in a way that makes them [...] feel okay about themselves. [...] They're very hesitant to start that conversation because they don't want to be belittled, especially by a doctor. [...] (1014)

At the same time, probing had to be done respectfully, given that the very nature of the clinician-patient relationship involved an asymmetrical power dynamic. Approximately one third of the practitioners brought up the role of obtaining patients’ consent: “[…] A huge piece of what I'm working on is […] asking […] consent to talk about those things, and if they're even an issue for them […] and not make assumptions that they are” (Dietician, 1008). Another dietician conveyed that she “always [thought] about autonomy and asking for permission […]” and would reassure patients of their “[…] choice […] to respond or not” (1006) whenever she enquired about what they were going through.

About one quarter of the practitioners conveyed that despite having awareness about extra-clinical factors that affected patients’ health, it was nevertheless challenging to incorporate such discussions into patient interactions. As one dietician remarked: “There’s still a part of me that [doesn’t] think a person expects me to ask these questions or […] it could just be […] my
own […] hang ups about talking about money” (1003). A General Practitioner explained that sometimes what stood in the way was his “lack of confidence in [his] own ability to sufficiently address the issues […] whereas […] if it was something that [he] felt […] confident […] assisting […] with more readily, then [he] would be more likely to address it.” (1019). A White dietician admitted that she approached sensitive topics such as racial oppression with caution: “[I hesitate to …] just outright say what is your experience based on […] the colour of your skin in accessing healthcare […] I don’t want […] insult the client or open up something that is really traumatic for them” (1004). Additionally, time constraints could undermine practitioners’ ability to have in-depth discussions about a patient’s social challenges. A General Practitioner explained: “the difficulty […] is you don't want to open a can of worms that's going to take 30 minutes when you have a 10-minute patient appointment” (1014). To work around these challenges, she attempted “to start the ball rolling and start thinking about things, […] and then […] refer them to somebody else who can do more counseling […] those deep dives” (1014).

For their part, the majority of patients expressed that they appreciated practitioners who proactively demonstrated a genuine interest in their lives by asking thoughtful questions. One patient described her dietician as a refreshing change from her previous practitioners: “I always felt that she was actually interested in me as a person […] The questions that she asked in response to […] whatever I had to say […] felt like she honoured […] where I was at […]” (2001). For another patient, there was no such thing as too many questions: “I'd rather they ask a lot of questions. […] I find it better for them to have the information. That way they can tailor it to care better for you” (2011). The kinds of questions patients wanted to be asked revolved around their priorities, concerns, and challenges. For example, a patient listed her desired
questions such as “How long have you dealt with this? What are your symptoms? […] What does your day to day […] look like?” (2018).

Moreover, this narrative approach represented an important shift away from weight-normative care towards PCC that sought to explore patients’ own goals, whether weight related or not. In one patient’s words:

[There should be] a curiosity for […] what the patient […] wants […] for […] their health or […] what the patient's ideals are […] and not putting on an assumption of […] you must want to lose weight […] or their […] own ideas of […] health onto the patient. (2007)

Another patient echoed that she appreciated how her doctor (not included in this study) would gently explore her preferences during weigh-ins: “she asked me if I want to be weighed and I can decline so […] as someone […] with an eating disorder that's super helpful” (2002). The patient explained how such simple yet thoughtful gestures could be healing for patients who experienced weight-related anxiety and who sought to let go of bodily scrutiny.

7.5.3 Centering Patients’ Own Wisdom about Their Conditions: “You Know Yourself Best, I Don’t Know You Best” (Practitioner)

While practitioners in the study had their own stances on the relationship between weight and health, almost all highlighted that effectively caring meant positioning patients as the experts. Over half of practitioners viewed obesity discourse and intentional weight loss as harmful, but sought to balance their ethical positions with patients’ goals. One dietician contended that the word obese was stigmatizing: “There's a lot of history with that word. […] I feel like it would […] perpetuate the perspective that […] a higher body weight is bad or negative.” (1008). Another dietician similarly challenged the paradigm of obesity management but emphasized honouring patients’ desires even if they contradicted her own: “I may have […]
this inner desire to want […] them to have a specific perspective [of acceptance] around their own bodies and weight. But […] that's just not my approach of forcing that on them. […] I just plant a seed” (1010). Another dietician said she preferred to facilitate client self-discovery despite her own opposition to dieting:

If a client's still very insistent after they've been seeing you for a while that they really want weight loss, […] I'll tell them […] let's do an experiment [with restrictive eating plans], since this is very important to you, and you know yourself best, I don't know you best. (1009)

She described how many of her clients reported observing a negative impact on their wellbeing after such experimentation, and through the process came to look beyond dieting and weight control. As the dietician remarked: “[the patient’s] own experience is much more valuable than anything anyone else can ever tell [them]” (1009).

The remaining practitioners were not categorically opposed to obesity discourse, but were careful not to prescribe weight management unless patients had specifically indicated an interest in pursuing this goal. For example, a dietician who worked at an obesity medicine clinic and who believed in the disease model of obesity stressed that treatment always accounted for patients’ values: “I work with my patients in regard to what matters to them. […] I do a lot of shared decision-making […] talking to patients about the pros and the cons [of different treatment options]” (1006). A General Practitioner similarly felt obesity posed health risks but refrained from assuming larger patients wanted or needed treatment for their weight. Instead, he took an exploratory approach:

I first ask them, […] what are their views about this? […] What have they tried? […] I do not have a prescribed approach. […] If you're wanting to help people, you need to align
with their belief system. […] You first need to understand it and […] determine where they want to go with it. [Then] you need to try and encourage and facilitate that. […] (1021)

All patients recounted the value of being placed “in the driver’s seat” (2018) and having their own expertise recognized. One patient articulated that she wanted to be “acknowledged as someone who […] is […] an expert as […] the only person who's had this body for […] 32 years […]” (2007). She highlighted the importance of practitioners asking patients if it was okay to talk about BMI or weight, explaining that it represented “a shift in the power relationship […] based on consent and permission, […] rather than […] one person being the expert and […] the one who […] can make all the decisions and […] withhold treatment or […] referrals” (2007). Another patient expressed appreciation that the clinic staff played a facilitative rather than directive role in his health journey:

They are here just to show you different methods of living. And it's up to you to decide if you want to choose this path or that path. […] There wasn't any direct instruction […]. (2012)

As with practitioners, patients’ views on weight differed, and about one third of patients rejected weight management entirely. One patient described directing attention away from weight loss towards overcoming internalized weight stigma. She praised her practitioner for respecting and supporting her goals: “She'll discuss suggestions and […] ask my opinion on them […] There are things that I don't agree with […] but…] she's open minded. She listens to me. […] She puts the power in my hands” (2004).

In contrast, other patients sought out weight loss yet wanted autonomy to define their own goals. As one patient described:
I don't feel like I was ever instructed to lose weight. [...] I brought forth myself [that] I wasn't comfortable at my weight [...] No one has ever said to me, this is how much weight you need to lose [...] which is actually different than other doctors I've had. [...] It was [...] very refreshing to [...] have doctors not be forceful with [...] putting a restrictive weight number on you. (2014)

Likewise, another patient showed appreciation for her clinic’s compassionate and non-judgmental approach to weight loss: “They give you strategies [...] to use if you choose to use them. [...] I’ve never heard [...] guilt invoking word [...] from that place” (2016). A patient who attended the same obesity clinic noted that the clinic’s intake assessment revolved around understanding the patient’s underlying goals: “Is [weight] what's important to you? [...] Is it your health? Or is it your weight? They ask you all those questions in the beginning” (2010).

As with other patients, she underscored the importance of being fully involved in decision-making around weight and health.

7.5.4 Promoting Equitable Care for Patients: “I Try and Advocate for Myself, Up to a Point” (Patient)

Because weight-based discrimination was prevalent in healthcare, most practitioners highlighted that being person-centred meant standing up for patients and ensuring that they received fair treatment. As a dietician declared: “To make sure that my patients are getting proper care [...] I bust weight bias and discrimination when I see it and hear it” (1006). A General Practitioner described how the injustices she witnessed against patients could feel “immobilizing” yet she recognized that her “incredible [...] power” (1017) could be used for activities such as writing letters for patients to access the care they needed.
Over one third of practitioners conveyed that advocacy could be challenging, particularly given the lack of like-minded practitioners. As noted by a dietician: “It’s very easy to feel isolated […] being the only one with this approach […]” (1001). She described having to tread carefully and “maintain professionalism” (1001) while contesting her colleagues’ views. Another dietician echoed that advocacy against weight discrimination was tricky when it involved other, higher ranked healthcare practitioners:

It’s a bit more delicate because you are dealing with a physician [who sees] themselves as the expert. So, in my notes, I […] delicately […] give my opinion as to why I think that the patient’s problem is not weight based or why I focus on behaviour change rather than weight itself […]. (1004)

Likewise, a dietician expressed frustration that patients often still deferred to the authority of doctors even when other weight-inclusive practitioners had attempted to educate them about the harms of dieting:

Unfortunately, people will still hold the doctor in higher regard. So if the doctor’s saying […] the keto diet is best, then [the patient is] going to be doing a keto diet […] even if they fail over and over again at it, and then […] blame themselves for failing at it. (1016)

Advocacy also entailed supporting the patient to speak up for themselves against weight discrimination. A social worker described techniques she had used to empower her clients such as “role playing to help the client be able to gain some confidence in […] explaining to their doctor why the doctor’s weight loss recommendation is not going to be helpful to them” (1012). A doctor working in obesity medicine similarly related how he taught his patients assertiveness skills:
If someone makes a [...] comment about your weight, stand up to them, right to their face and say it's not appropriate, how dare you talk to me about my weight and offer me advice. And if it's a physician, report them to the College of Physicians and Surgeons. [...] (1020)

Nonetheless, all practitioners recognized that individual-level approaches to person-centered care such as defending and empowering patients had constraints in the face of a fat-phobic society. As a General Practitioner remarked, speaking up on behalf of larger patients was not a straightforward process. She recalled that when she had offered to talk to her patient’s specialist, the patient’s first response had been “oh god […] don't ever draw attention to me” (1014). Similarly, a dietician lamented that being deluged with anti-fat messages was “very demanding of the patient […] because […] it calls for the patient to really tap into […] deep within themselves, to find the strength to deal with this crap that shouldn’t be happening in […] the first place” (1001).

Over half of the patients reported attempts to self-advocate during negative encounters with clinicians and others in their social circles. One patient mentioned resisting clinicians’ attempts to force tests on her solely because of her BMI:

[I don’t want to] let […] outdated ideas on BMI and health impact the level of care I'm receiving. [Self-advocacy] looks like asking more questions and getting […] fuller answers on why you're asked to do certain things. […] Where's the research? […] What is this based on? (2006)

Another patient asserted that self-advocacy meant not settling for suboptimal care and finding alternative practitioners who were better able to meet her needs:
If [...] the person I'm seeing is not really into social justice or [...] treating me [...] as a person as opposed to a number, [...] I'll ask to go see somebody else. [...] I'll tell my doctor [...] I didn't really like them [...]. My doctor [will say] okay, I have somebody else who's better in mind for you. (2009)

Patients also asserted that advocacy was often limited by broader socio-cultural constraints. One patient described with a sense of resignation that she could only do so much to change others’ deep-seated weight-bias: “I try and advocate for myself, up to a point. [...] But at the end of the day, [...] I can't rely on [my doctor]. [...] So I don't spend as much energy trying [...] to explain where I'm coming from [...]” (2007). Another patient noted the challenges of larger bodied people being taken seriously when they were advocating for weight-inclusivity and felt that the interviewer’s thin privilege could be used responsibly to raise awareness about the issue:

People will take [...] weight inclusive words from you, they won't take it from me [...]. If people in smaller bodies stand up and say [...] diet culture is wrong [...] then people will listen [...] take it in a little easier than somebody [...] like me ranting and raving because they're going, you're fat, you got to do that. (2003)

Likewise, a patient asserted that individuals should not be expected to single-handedly solve the problem of weight-based discrimination: “I think we're [...] told that [...] if only I can be better then [...] I can change the world. [...] I mean, it's good to start with ourselves but systemically, [...] there has to be a huge change” (2002). In her view, the solution was about “finding where [...] self-care and [...] community-care can coexist” (2002), which meant not only taking care of herself, but being part of a community where she could leverage her privilege to provide care that benefitted others.
7.5.5 The Benefits of Interprofessional Collaborations and Community Linkages:

“It Can't Happen in a Silo” (Practitioner)

All practitioners highlighted that interprofessional collaborations and community linkages were crucial for a social justice-informed approach to PCC that entailed addressing patients’ intertwined health and social needs. In the words of a dietician: “Social justice [has to] happen across the board. It can't happen in a silo” (1006). A social worker remarked that “more voices together are sometimes helpful depending on the needs of the person if they're more complex” (1007). Furthermore, when seeking to address patients’ needs, practitioners did not automatically assume that larger patients had weight-related health issues; rather, they sought to identify what kinds of support would benefit patients most. A General Practitioner emphasized that “being larger doesn't necessarily mean that someone's having health issues, but if they're having health issues, then […] we [address those issues] with the people that they need” (1017). A dietician reported that when she received referrals from a provider that were weight related, she did not take the referral at face value and would “find out from the patient exactly what […] the issue [was]. It may not be weight related at all” (1004).

Given their difficulties finding similarly oriented practitioners who adopted a weight-inclusive and social justice lens, almost half of the practitioners expressed that they were prudent about patient referrals, so as to avoid causing patients more harm. A General Practitioner stated:

I'm […] constantly worried about sending patients to specialists [who] are going to traumatize them. […] Knowing that someone is social justice oriented is super important and […] helpful […] But it's tough because […] we also oftentimes have to just […] try to get people to whoever can see them sooner […] (1017)
In particular, mental health interventions and referrals were mentioned by most practitioners as key to addressing patients’ internalized weight stigma and emotional issues related to weight. From this perspective, the psychology of “fearing fatness and feeling fat” (Windram-Geddes, 2013, p. 42) were no less important than the material reality of fatness and its accompanying health issues. As one dietician remarked, “the literature shows that weight bias internalization affects everybody across the BMI spectrum” (1001) rather than just those of heavier weight, suggesting that weight stigma is in itself an important health issue independent of BMI.

Similarly, another dietician noted: “I […] had a fair number of referrals on to […] counselling support […] because the issue isn’t that [they’re] fat but rather, [they’re] feeling bad about being fat” (1002). A social worker highlighted that weight-related anxiety was intertwined with other social factors such as racism, and had to be addressed with an intersectional lens. She described working with clients of color to explore issues related to disempowerment, control, and belonging:

Wanting to […] fit in […] be a part of this […] culture sometimes can […] lead to an increased desire to restrict food and lose weight. […] That’s what they sort of feel like they have control of. They can’t change their race, but at least they […] become thin and then fit better with all of their white colleagues […] (1012)

Apart from collaborative efforts with fellow clinicians, all practitioners emphasized linkages to social and community services. As a dietician explained, enhancing patients’ wellbeing entailed improving the social determinants of health: “It’s very hard to feel food secure or to work on better nutrition or […] physical activity if you don't have stable housing” (1006). A social worker remarked that since social isolation was a key factor to tackle, she had facilitated her patients’ participation in activities such as “accessible gym programs, […] art
classes through a local church, […] more volunteer programs to get them connected” (1007). These perspectives underscore that weight itself was not necessarily the core issue that larger patients needed support with, and what took priority was assessing patients’ wellbeing holistically to see what would benefit their lives most.

Most patients appreciated practitioners collaboratively making referrals to other practitioners and community services to address the multi-faceted nature of their health conditions. Praising her clinic, one patient mentioned that “they'll look into […] every […] facet of [your health]” (2015). She pointed out that it was a welcome change from “other clinics and other doctors [who did] everything by piecemeal, and [not] want to […] touch an area that's not theirs” (2015). Another patient acknowledged that practitioners understandably had gaps in their knowledge, and wanted them to “take some time to actually refer [patients] somewhere […] if they [didn’t] know [how to deal with an issue]” (2020). One patient suggested that practitioners could ensure continuity of care by asking questions such as: “Is there anything that we can do for you after you leave this setting? […] Are there any resources that we can refer you to […] after you leave this office […]?” (2011). Another patient stated that in order for referrals to be helpful, they had to account not only for patients’ health conditions but also their socio-economic positions:

Sometimes […] family doctors or clinicians will say […] here's a referral to go to a counselor, [or] a dietitian, [or] a nutritionist […] And I can't afford to go to any of those places. […] I don't know where to go from [there]. (2014)

She stressed the need for clinicians to be more sensitive to patients’ barriers to care and to provide free or low-cost resources for lower income patients.
A couple of patients spoke up about the lack of interprofessional collaboration they had observed in healthcare. One patient related the “gap in services” (2002) that was characterized by a lack of dialogue between professionals serving the same client. She explained that neither her dietician nor psychologist had addressed body image issues with her: “It was sort of like […] my dietician assumed that I would be discussing those issues with my psychologist, and then my psychologist assumed that I would be discussing those issues with my dietician” (2002). In her view, “branches could be talking to each other more” (2002) to ensure that patients did not fall through the cracks.

7.6 Discussion

Collectively, the five themes demonstrate how patients and practitioners experienced, enacted, and understood social justice-informed PCC. To begin, they underscored that the quality of compassion was brought to the forefront of clinical practice despite the prevalence of evidence-based practice, and its elevation of scientific knowledge above patient experience. They noted that practitioners who displayed curiosity about the patient’s world by proactively asking questions fostered environments in which patients felt safe to disclose their concerns without judgment. Both practitioners and patients valued approaches that allowed patients to uncover their own expertise without having pre-determined goals imposed on them. Participants sought to defend the right for patients to receive equitable and weight-inclusive care, though their efforts were often undermined by a system steeped in weight stigma. Finally, they suggested that the delivery of equitable and comprehensive healthcare required interprofessional collaboration as well as mobilizing and connecting patients with community resources.

Findings from this study must be contextualized within broader discursive tensions between evidence-based practice (EBP) and person-centred, compassionate care (Baker et al.,
The dominant discourse in medicine continues to be EBP, which has privileged research-based scientific knowledge while silencing other kinds of knowledge such as patient experience (Baker et al., 2018). In line with Natvik et al.’s (2021) narrative phenomenology of a larger bodied female patient, participants’ accounts in the present study reveal how “medical and experiential narratives seem partly incongruent, favouring normalization of bodies and lives over uncertainties, failure and vulnerability” (p. 258). However, Heney (2016) has suggested that rather than position EBP and PCC as diametrically opposed, we can reconcile the insights from the two models. Evidence matters in clinical practice, though what is needed is a “broader understanding of what counts as evidence” (Heney, 2016, p. 117), particularly the recognition of patient narratives as a form of evidence. The transformative power of research exploring the historically subjugated narratives of larger individuals in healthcare lies in exposing their experiences of marginalization, opening up spaces where resistance and change are possible, and generating new knowledge about health and illness (see Bombak et al., 2016; LaMarre et al., 2020; Pausé, 2014).

While the debates around obesity persist, participants’ accounts indicate that qualities such as narrative competence, compassion, and empathy associated with PCC must be combined with scientific evidence on the complexity of weight and health to effectively address patients’ needs. This finding supports past research demonstrating that practitioners who asked about patients’ lives in a sensitive and caring way motivated patients to disclose their symptoms and concerns (Halpern, 2001). In the present study, patients had varying health goals, ranging from weight management to fat acceptance and encountered a range of structural forces such as discrimination and lack of social support that impacted their health. Most patients shared the sense that clinicians honoured their needs, goals, and expertise. Clinicians in the study displayed
principles of PCC by transcending weight-specific outcomes derived through a biomedical lens, and by accounting for patients’ subjective understanding of their health priorities. Thus, clinicians encouraged patients to communicate the extent to which their weight and other determinants of health affected their day-to-day living, if at all. Even clinicians who subscribed to the obesity model were careful not to lead with weight loss as a prescription and demonstrated respect for a patient’s decision about whether or not they desired to lose weight. In turn, patients who sought out weight management reported that they were able to approach treatment as a partnership rather than as a directive imposed on them. These findings depart from prior research on PCC for obesity that draw on principles such as patients’ goal ownership and increased self-efficacy to facilitate their compliance with weight loss practices (see Armstrong et al., 2011; Wakefield & Feo, 2017). Participants in the study eschewed the notion of adherence to obesity treatment, which is part of the same moralistic and blaming discourse that demonizes larger patients for not taking responsibility for losing weight (Lupton, 2013).

Correspondingly, both practitioners and patients felt compelled to advocate for weight-inclusive treatment as part of a person-centred approach. The theme of patient advocacy aligns with past research indicating that though larger patients experienced healthcare as a persistent struggle, some attempted to assert their needs with their healthcare providers or find alternative providers who were able to honour their preferences (see Buxton & Snethen, 2013; Merrill & Grassley, 2008). Buxton and Snethen (2013) report that patients in their study confronted their initial discomfort with being assertive because they believed that they “[had] a responsibility to say what they want and to seek it out” (p. 257). In the present study, however, both patients and practitioners perceived self-advocacy to be a valuable trait, yet recognized that patients’ abilities to assert themselves were dependent on their social positioning. Thus, they were careful not to
place the onus on patients to single-handedly resolve the systemic problem of inequitable treatment. This finding supports research by LaMarre et al. (2020) on the healthcare experiences of women and trans men diagnosed as ‘overweight’ or ‘obese’ who are pregnant or seeking to become pregnant. LaMarre et al. (2020) found that patients who advocated for themselves did often receive better care, though patients lamented that they were compelled to engage in this level of self-advocacy. Rather, what was needed was a collective shift towards more inclusive healthcare spaces that were accepting of differences around weight and other intersecting identities (LaMarre et al., 2020). In the present study, participants’ accounts similarly demonstrate the importance of systems-based practice, which refers to recognizing and responding to the broader system of health care and seeking out innovative solutions (Bourgois et al. 2017). Hence, the vast majority of participants rejected the notion of individual responsibility for health, instead emphasizing interprofessional collaboration and community linkages, though some challenges in executing these goals remained. For example, practitioners found it difficult to make appropriate referrals due to a lack of weight-inclusive practitioners in a system rife with weight stigma. This theme of enhancing collaboration among healthcare practitioners to improve patient outcomes has been found in previous studies that examine IPC for obesity management, though such studies adopt a weight-normative perspective. As Aboueid et al. (2018) demonstrate in their systematic review of IPC for obesity with a focus on dietetic referrals, dieticians are critical team players because nutritional counselling has been shown to enhance patient adherence to lifestyle modifications. Other studies on weight management across pregnancy and postpartum care likewise explore the important role of IPC between midwives and maternal and child health nurses to provide basic advice on establishing healthy food environments in the home (see Walker et al., 2019). In contrast, the present study takes a stance
that IPC is beneficial not necessarily for the narrowly defined goal of weight management per se, but for advancing social justice through holistically addressing interlocking behavioural and social factors implicated in patients’ overall wellbeing.

7.7 Limitations

Practitioners who were successfully recruited were limited to medical doctors, dieticians and mental health professionals. Research indicates that weight stigma is also rampant amongst other clinicians such as physiotherapists (Setchell et al., 2015) and nurses (Mulherin et al., 2013). The majority of the patients enjoyed good access to healthcare, including dietetics and mental health counselling, which are not covered by Canada’s public health insurance. Future studies could examine the perspectives of larger patients who encounter more severe health inequities in basic care to offer a more comprehensive understanding of patient needs.

7.8 Conclusion

To our knowledge, the present study is the first that draws on perspectives from the practitioner-patient dyad to examine how an explicit social justice framework addressing systemic inequities can inform PCC for larger bodied patients. The findings illustrate that despite the divergence in participants’ perspectives around weight and health, they shared a commitment to PCC by promoting patient self-determination and acting on systemic factors that affect health outcomes. In light of participants’ challenges in finding weight-inclusive and person-centred practitioners, it is pertinent to raise awareness about such approaches amongst interdisciplinary healthcare teams and to ensure that patients receive consistent messaging across the board. Ultimately, a social justice-oriented approach to PCC for larger patients requires both individualized and collective approaches that integrate micro-level strategies for individual
healing and empowerment with a macro-level framework that targets the broader social determinants of health.
Chapter 8: General Discussion

The study was structured around four main research questions, namely how practitioners and larger patients understood social justice, how practitioners integrated social justice principles into their clinical practice, what challenges practitioners grappled with when caring for larger patients, and how patients’ experiences were impacted by social justice informed care. To explore these questions, in-depth semi-structured interviews were conducted with a total of 42 Canadian participants - 22 healthcare practitioners and 20 patients of the same practitioners. Collectively, the three findings chapters present a social justice framework for clinical interventions related to weight, and offer practice-oriented insights for weight-inclusive, structurally-competent, and person-centered care. As the first findings chapter elucidates, greater conceptual clarity is needed on what a social justice approach to tackling obesity entails. Drawing on a critical realist theoretical framework, the chapter uncovers the ontological and ideological assumptions underpinning participants’ varying conceptualizations of obesity. Specifically, it explores the tensions in clinical settings between individualism and structuralism, and realism and constructionism. Findings chapter two expands on the notion of structuralism explored in findings chapter one, examining how relational, structural, and systemic power relations must be addressed to integrate socially just practices into healthcare. Building on the insights from findings chapter two on structural competency and critical consciousness, findings chapter three interrogates the emerging paradigm of person-centred care (PCC), exposing some of the limitations of the current PCC approaches to treating obesity in the research literature. It highlights the importance of reconfiguring PCC through an explicit social justice lens. Such an approach to PCC is essential in order to uphold patient self-determination, while situating individual agency within the broader social context and power relations.
The findings from the first chapter indicate that congruent with a social justice approach, the vast majority of practitioners shunned individualism, and accounted for the broader determinants of weight and health. These findings contrast with previous research suggesting that many practitioners adopted biologically deterministic notions of obesity (Saldaña-Tejeda & Wade, 2018) and emphasized individual-level lifestyle factors such as nutrition and physical activity as solutions to the problem of weight gain (Schmied et al., 2011; Stone & Werner, 2012). While practitioners in this study rejected individualistic ideologies, their social justice orientation played out differently depending on whether they regarded obesity as either primarily a social construct or a biomedical fact, which in turn likely shaped how their patients understood and experienced social justice informed care. Participants’ varying conceptualizations of obesity are reflected in three main approaches. Falling on the realist end of the spectrum, the first approach promotes a compassionate understanding of obesity as a disease to reduce blaming and shaming attitudes towards larger people. This finding builds on previous research suggesting that patients desired non-judgmental support and sensitivity from practitioners around weight management (Chugh et al., 2013; Malterud & Ulriksen, 2010; Ward et al., 2009). Furthermore, similar to what Puhl et al. (2008) found, some patients conveyed that the complex interplay of factors contributing to obesity should be recognized, and that they should not be held personally responsible for their weight status. Participants’ emphases on the environment and structural roots of obesity echoes prior research with parents and healthcare practitioners who highlighted that weight issues could be attributed to factors such as the availability and cost of healthy foods and access to exercise facilities (Withall et al., 2009).

The second approach taken by participants involves ambivalence towards obesity discourse, and neither aligns fully with the dominant biomedical model nor fat acceptance. These
participants displayed awareness about the strong anti-fat bias in obesity science, yet were not impervious to the widespread messages equating fat with poor health. This tension between competing discourses is consistent with LaMarre et al.’s (2020) finding that “participants sometimes internalized the anti-fat messages they received, and fluctuated between seeing their bodies as good and problematic” (p. 348). Participants’ ambivalence about the biomedical model of obesity mirrors past research (Jeffrey & Kitto, 2006) suggesting that nurses continued to draw upon BMI in their practice, even though they viewed this measure as fundamentally incompatible with their holistic and humanistic philosophies of health.

The third approach adopted by participants is characterized by a stronger political stance against the moralistic tone of obesity discourse, highlighting the “contested nature of this terrain” (Monaghan et al., 2019, p. 12). Participants’ views of obesity as a social construction support earlier studies with patients who regarded the war on obesity as reinforcing judgmental and stigmatizing notions of health and normality (LaMarre et al., 2020; Pausé, 2014) and with practitioners who challenged the cultural narrative of obesity as an epidemic (Malatzky & Glenister, 2019).

On the whole, participants in this study demonstrated a range of different preferences around weight-related terminologies, which corresponded with their conceptualizations of obesity. Some patients expressed that they found comfort in medical terms such ‘obese’, which they felt freed them from blame, and others took pride in using ‘fat’ as a descriptor, though a number of patients who supported fat acceptance were not emotionally prepared to take ownership of ‘fat’ because of past trauma related to fat shaming. Prior research similarly shows that patients held differing views on terms to describe body weight, with some considering terms associated with fat to be the least desirable (Dutton et al., 2010; Volger et al., 2012) and others
viewing the term obese to be more stigmatizing (Ward et al., 2009). However, such research is limited in their sole focus on patients undergoing treatment for obesity, which highlights the importance of further research exploring the perspectives of patients who do not subscribe to the dominant biomedical model.

Findings chapter two extends the critique of individualism, drawing on the key frameworks of structural competency (Metzl & Hansen, 2014) and critical consciousness (Kumagai & Lypson, 2009) to outline four main themes that provide a framework for integrating social justice into healthcare practice. Firstly, participants displayed an awareness of how their concurrent experiences of marginalization and privilege shaped the clinical interaction. The findings indicate that practitioners’ first-hand experience with discrimination, including weight stigma, allowed them to foster greater empathy towards patients’ struggles. In contrast to prior research (Petrich, 2000; Sikorski et al., 2013), practitioners did not default to the common stereotypes of larger patients as lazy, unattractive, self-indulgent, and ill-disciplined. For their part, half of the patients in the study expressed that practitioners who had struggled with weight were more relatable, which differs from earlier research demonstrating that patients questioned the credibility of larger-bodied doctors (Puhl et al., 2013). Patients’ accounts also support research by Koball et al. (2018) suggesting that patients responded positively to practitioners who showed empathy by validating their difficulties with weight loss, which, in turn, allowed patients to feel a sense of common humanity with practitioners and less alone in their struggles. Secondly, participants in the study demonstrated an understanding of multiple oppressions co-existing in lived experience, though there appeared to be a divergence between additive and interactive understandings of intersectionality. This divide reflects broader debates in intersectionality scholarship about whether social categories are inseparable or separable (see
McCall, 2005 for an overview of the anti-categorical, inter-categorical, and intra-categorical approaches to intersectionality). I draw on Gunnarsson’s (2017) characterization of categories as both distinct and unified to denote how each category has a distinct reality with effects that cannot be reduced to the effects of other categories, while simultaneously being shaped by other categories. At the same time, I recognize that interactive understandings of intersectionality have often been absent from the existing research on weight stigma, which tends to isolate different inequities such as racism and weight stigma to examine their independent effects (see Bucchianeri et al., 2013; Gee et al., 2008). As the work of anti-racist fat liberation scholars and activists suggests, focusing solely on additive effects of oppressions runs the risk of obscuring how fat phobia historically emerged from racism, sexism, and classism, and thus cannot dismantled as an isolated system of oppression (see Harrison, 2021; McPhail, 2017; Strings, 2019). Thirdly, the findings shed light on another key debate within social theory, namely the role of social structure versus individual agency (Lupton, 2013). Participants in the study reconciled micro and macro approaches by viewing individual health behaviours related to weight and otherwise as bounded by broader social conditions, while cultivating peoples’ situated agency to improve their wellbeing in the face of external challenges. This notion of situated agency recognizes that individuals are shaped but not determined by structures and have the capacity for critical reflection and resistance. Structural-level mechanisms, while powerful, do not impact individuals in exactly the same way and will be mediated through individuals’ subjective perceptions, daily actions, and behaviours (Evans, 2002; Houston, 2001). Indeed, practitioners in this study supported patients to make positive lifestyle changes within their locus of control, yet rejected the notion that health and weight were the sole responsibility of the individual. This finding is consistent with prior research by Malatzky and Glenister (2019), who
found that GP participants challenged moralistic assumptions about larger patients being ill
disciplined and out of control. Research shows that the prevailing discourse of individualism
nevertheless continues to exert a profound influence on larger patients, who grapple with
internalized weight stigma and self-blame (Lewis et al., 2011; Thomas et al., 2008). Earlier
studies suggest that even larger patients who held an awareness of the social determinants of
weight and the complex challenges involved in weight management tended to locate
responsibility within themselves (Kirk et al., 2014; Pausé, 2014). In contrast, the majority of
patients in this study described their journey from self-blame to self-compassion, and highlighted
the need to practice acceptance of the various social factors beyond their control, even as they
worked on modifying lifestyle habits.

Findings chapter three situates healthcare at the nexus of “technique (effectivity) and
heart (affectivity)” (Jovell as cited in Bimbela Pedrola, 2018, p. 78), shedding light on the
humanistic and narrative elements of care against the backdrop of evidence-based medicine. The
findings suggest that practitioners’ knowledge about the evidence on weight and health, as well
as the social determinants of health, is only part of the picture; practitioners also need to be
equipped with the interpersonal skills to translate such knowledge into effectively
communicating and working with patients, other practitioners, and organizations outside the
clinic. The findings expound on characteristics of social justice-informed PCC, namely: 1)
emphasizing compassionate care and narrative competence, or the ability to elicit, acknowledge,
understand, and act on patients’ narratives to create a sense of emotional safety and connection;
2) displaying curiosity about patients’ lives beyond their presenting medical issues, particularly
by asking difficult questions to help uncover underlying needs and concerns; 3) centering
patients’ own wisdom about their conditions, and positioning them as the experts in their own
4) promoting patient advocacy, which refers to increasing patients’ capacity to access information and represent their own interests when interacting with healthcare practitioners; 5) enhancing interprofessional collaboration and community linkages, to more fully address patients’ complex health needs. These findings must be understood against the backdrop of the tensions between evidence-based practice (EBP) and person-centred, compassionate care (Baker et al., 2018; Engle et al., 2021; MacLeod, 2011). The prevailing approach continues to be EBP, which has been critiqued for the tendency to elevate scientific knowledge and standardized processes over subjective patient experiences, preferences, needs, and values (Baker et al., 2018).

In this study, patients conveyed how their practitioners (not interviewed in this study) had made quick assumptions based on their appearance without delving into their life stories, and imposed on them healthist practices of discipling the body, which highlights the importance of restoring a more compassionate, person-centred approach to care. Patients’ accounts of their challenges navigating the healthcare system echo findings from Natvik et al.’s (2021) narrative phenomenology of a larger bodied female patient, which demonstrate how “medical and experiential narratives seem partly incongruent, favouring normalization of bodies and lives over uncertainties, failure and vulnerability” (p. 258). However, the patient-practitioner interactions in this study illuminate the potential to reconcile EBP with PCC, and its related approaches of mindful practice, compassionate care, narrative medicine, or relationship-centred care (Charon & Wyer, 2008; Engle et al., 2021; Heney, 2016). As Heney (2016) posits, we cannot deny the value of drawing on evidence to guide clinical practice, though we need to establish a “broader understanding of what counts as evidence” (p. 117), particularly in terms of integrating patient narratives into the evidence base. Correspondingly, participants in the study expressed that the principles of PCC could be applied by moving beyond health and weight-specific outcomes
derived through a biomedical lens, and by accounting for the patient’s subjective understanding of “success, health status, weight history, and goals related to appearance and body size” (Drury & Louis, 2002, p. 559-560). This finding supports prior research demonstrating that regardless of whether patients sought to lose weight, they wanted practitioners to pay attention to health concerns they brought up, rather than associating all their health issues with excess weight (Buxton & Snethen, 2013; Malterud & Ulriksen, 2010). Findings in this study also align with prior research indicating that participants felt healthy even though they were diagnosed as obese; their definitions of health transcended the narrow measure of BMI and were based on a range of factors such as how they felt, their ability to do what they wanted, and whether they experienced any chronic medical problems (Buxton & Snethen, 2013). As found in previous studies (Buxton & Snethen, 2013; Ward et al., 2009), participants in this study reported having positive experiences when their healthcare providers took the time to listen to their stories and develop a holistic understanding of them. It appears that at the crux of it, patients yearn for their practitioners to respect them as persons rather than identify them by their diseases (Buxton & Snethen, 2013).

8.1 Implications for Theorizing on Obesity, Health, and Social Justice

Weight-related research often continues to be studied within disciplinary silos. On one hand, the dominant biomedical perspective tends to exclude contextual factors such as socio-cultural and gender norms, lived experience, and the voices of larger people (Cooper, 2010). These dominant discourses do not typically account for how “what is commonsensically seen as natural and thus destined to be” (Gunnarsson, 2013, p. 3) is in fact socio-historically constructed and thus subject to change over time and place. On the other hand, some theorists within critical fat/weight studies’ have been primarily concerned with the body as socially constituted rather
than physically constituted, thereby foreclosing more productive engagements with science and the natural forces that remodel themselves in interaction with the world (Warin, 2015; Yoshiwaza, 2012). There is also a dangerous tendency of some strands of fat activism to present fat agency as voluntaristic - a matter of sheer willpower - and to disregard the material dimensions of the body (Patterson & Johnston, 2012). Furthermore, some individualistic approaches that elevate the notion of ‘fat by choice’ may downplay the material realities of those who do not choose to be fat, but are fat because they encounter socioeconomic disadvantages that may impact biophysiological processes such as inflammation and hormones (Yoshizawa, 2012), as well as behavioural choices around food and physical activity (Williams, 2017).

Although some critical researchers both engage with the science of obesity and consider the political underpinnings and repercussions of such discourses (see Bombak, 2014; Yoshizawa, 2012), other researchers continue to place discourse at the forefront (see LeBesco, 2001; Saguy & Almeling, 2008). From a critical realist standpoint, discourse is merely one layer within a stratified ontology (Flatschart, 2016). Thus, we cannot succumb to the epistemological fallacy that only discourse – or meaning-producing activity – constitutes reality (Flatschart, 2016), given that there are underlying mechanisms that may escape our perception and knowledge. Stories, while often transformative, cannot “reshape the base matter of ourselves: those processes go on beyond our ultimate control” (Cregan, 2006, p. 161).

Drawing on the metatheory of critical realism and complementary insights from complexity theory to foster transdisciplinary analysis, my research offers an understanding of fat that incorporates the social sciences and natural sciences; this goes a step further than an interdisciplinary approach in fostering the mutual crossover and transformation of disciplines (Yoshizawa, 2012). A transdisciplinary perspective is underpinned by the notion of complexity,
which disrupts positivist understandings of straightforward causality represented “in the boxes and arrows often used to describe the factors that contribute to health or illness” (Glouberman & Zimmerman, 2002, p. 11). Instead, it uncovers new ways to understand social and biological systems and the complexity of their interactions (McCall, 2005). From this perspective, the natural and social worlds comprise a range of open heterogeneous systems each with distinct mechanisms beyond our ability to directly control (Houston, 2001). Given the combined effects of an open system’s mechanisms, which may be both countervailing and complementary, we can never predict or determine outcomes with certitude (Houston, 2001). Accordingly, health and weight are conceptualized as probabilistic and emergent, shaped by many factors, social and biological, “interacting not only with the individual but also with each other” (Glouberman & Zimmerman, 2002, p. 11).

This transdisciplinary approach reconciles both the discursive and material elements from critical biomedicine with critical fat/weight studies, highlighting the need to move towards a biosocial model that incorporates biology, social positionality, place, and generation (Yoshizawa, 2012). Unlike the dominant biomedical model that reduces the social determinants of health to inherent biological differences between cultural groups, the biosocial model understands disease as an embodied and mutable biological expression of social conditions such as discrimination, marginalization, and exclusion. This biosocial perspective counters biologically deterministic, reductionistic, and essentialist explanations of obesity that mark certain bodies as riskier through their “anticipation of fatness” (Warin, 2015, p. 66). Instead, it emphasizes developmental plasticity through the commingling of an individual’s external and internal environments (Warin, 2015). Accordingly, it promotes an understanding of fat as the materialization of biology, cultural norms, social practices, economic structures, and physical environments (Rice, 2015;

8.2 Implications for Clinical Practice

The study findings demonstrate the importance of bringing together frameworks of structural competency, critical consciousness, evidence-based medicine (EBM), and compassionate care to advance social justice in healthcare. An understanding of structural forces such as historical racism, oppression, and trauma, serves as the bedrock for integrating social justice into healthcare (Bourgois et al., 2017). In the absence of a structurally-informed perspective, even providers with the best of intentions may unwittingly overlook and reinforce health inequities when caring for patients (Farmer et al., 2006). Evaluative studies indicate that teaching practitioners to develop structural competency and critical consciousness is helpful for subverting the prevailing ideologies of individualism and equality in healthcare (Neff et al., 2016). Upon completion of the training, practitioners were better able to identify how structural forces influenced both patient health and the clinical encounter, as well as develop strategies to address these structural forces within and beyond the clinic (Neff et al., 2016). As my study findings indicate, practitioners’ ability to reflect on their own biases and incorporate an understanding of the social determinants of health into the clinical encounter translated into a stronger practitioner-patient relationship, and an improved experience for larger patients. At the same time, practitioners’ accounts alluded to how critical consciousness is at best partial and that mechanisms of power may continue to exert an effect independent of human perception (Seal, 2016). One way to address this limitation may be to expand consciousness through collective
action, which entails relying on others to uncover individual blind spots and finding connections that “enable people to find ways of changing and challenging the structural forces that bind them” (Seal, 2016, p. 270). Given that practitioners in the study conveyed the isolation they experienced and the challenges of finding like-minded practitioners, it would be beneficial to foster more opportunities for networking, collaboration, and knowledge exchange.

Furthermore, a structurally informed framework of care for larger patients involves understanding weight stigma not as an isolated issue but as interlocking with other systems of oppressions; consequently, practitioners must strive to dismantle not just one system but all other interlocking systems (Fellows & Razack, 1998; Ion et al., 2018). The study findings indicate that although practitioners acknowledged how multiple structural forces played out in patients’ lives, not all practitioners articulated the ways in which anti-fatness was rooted in racism, colonialism, White supremacy, and misogyny. Historically, biomedicine’s reductionistic focus has tended to lead to “one-dimensional accounts of health inequality”, whereby social structures are viewed as “parallel, rather than as being mutually constitutive and maintaining each other” (Ion et al., 2018, p. 99). This gap in awareness amongst practitioners highlights the need to cultivate intersectional thinking in healthcare education so that practitioners can more effectively engage in ethical anti-oppressive practice. Such practice can include understanding the complex histories of social trauma involved in patients’ lived experiences, identifying domains of privilege and power on both individual and institutional levels, and speaking out against oppressive attitudes and behaviours in healthcare practice. This emphasis on action-oriented ethics suggests that educational programs must go beyond merely imparting theoretical knowledge to equipping practitioners “with the moral courage and personal resilience required to do the right thing in difficult circumstances” (Ion et al., 2018, p. 99). Nonetheless, as Gallagher (2011) contends,
moral courage is a contextual quality that cannot be understood in a vacuum; rather, it is facilitated when a practitioner’s desire to act in an ethical manner is aligned with a practice culture that is explicitly committed to social justice, and welcomes critical reflection and open dialogue.

The study findings also demonstrate the importance of revitalizing the model of EBM, beginning with fine-tuning the evidence on weight and health. Even though EBM is regarded as the gold standard, the quality and reliability of evidence from clinical studies can be influenced by various factors such as the researchers’ own biases and vested interests, the manipulation of findings to prove hypotheses, and errors in peer reviews (Henry, 2006). While such uncertainties in diagnosis, prognosis, and treatment are rarely disclosed in medicine (Henry, 2006), clinicians in this study displayed humility in recognizing the limits of their knowledge and the evolving politics of obesity research. Many of them were skeptical about the weight-health connection and well acquainted with the research on the harms of dieting, restrictive eating, and weight loss (see Bacon & Aphramor, 2011). Thus, they emphasized the need to holistically assess patients’ health concerns rather than lead with weight loss as a prescription. While patients showed appreciation for practitioners who were able to adopt a weight-inclusive and HAES approach, they lamented that many other practitioners (who were not interviewed in this study) rigidly focused on certain types of evidence, displayed strong anti-fat bias, and unduly focused on their weight. These accounts from participants shed light on the importance of increasing practitioners’ exposure to critical perspectives on obesity that challenge the taken-for-granted associations amongst body weight, health, and morality. Additionally, clinicians can be encouraged to exercise greater transparency and admit to clinical uncertainties, in order to help patients make more informed decisions around their treatment and care (Henry, 2006).
In line with a patient-centred, narrative-based approach to care, EBM should be expanded such that patients’ narratives constitute evidence (Heney, 2016). The current model of EBM poses limitations in that findings are derived from what complexity theory terms a ‘closed system’ or a system “partially sheltered from external forces” (Turner et al., 2018, p. 73), with controlled variables and static cause-effect relationships. Thus, such findings may not necessarily be applicable to the actual patient in the complex, unpredictable, and non-mechanical ‘open system’ of the real world (Braithwaite et al., 2018). Showcasing a diverse array of patient narratives during healthcare education and training may help practitioners to more fully grasp such complexity, as well as challenge their deeply ingrained beliefs and biases about obesity. In particular, alternative perspectives, namely from patients whose goals do not align with the weight-centric model, should be prominently featured. Likewise, strategies to reduce weight-stigma amongst practitioners must operate from a patient-centred lens that prioritizes patients’ own wisdom about their bodies. In light of the prevailing disease model of obesity in healthcare, current weight bias reduction training amongst healthcare professionals is still premised on the notion that patients’ excess weight is necessarily a problem to be eradicated (see Alberga et al., 2016 for a review of studies on weight bias reduction). Some of these interventions (e.g., Persky & Eccleston, 2011) were able to reduce weight bias in practitioners by raising their awareness of the uncontrollable causes of obesity such as genetics and environmental factors. However, these interventions still place the power of diagnosis in the hands of so-called obesity experts, and fail to represent the voices of larger patients who do not desire medical intervention on their weight. As participants in my study have expressed, truly countering fat phobia requires a critical interrogation of obesity discourse and the war on fatness and the ways in which they interlock with other systems of oppression. In line with a transdisciplinary approach, education for
practitioners should bring together both realist and constructionist perspectives from the social sciences and natural sciences. This approach would foster a deeper awareness of the complex interplay of biological and social factors in shaping health - and the diverse meanings people attach to eating, physical activity, their bodies, and health itself (Rich et al., 2011).

The study findings demonstrate that caring for patients requires practitioners to combine their knowledge about structural factors and the science on weight with interpersonal skills such as empathic listening and thoughtful questioning. Practitioners expressed that although displaying compassion for patients was essential to their practice, this affective domain had historically been dismissed as a ‘fluffy’ approach compared to rationality and knowledge. Underpinning this characterization are Cartesian dualisms of mind/body, reason/emotion, and nature/culture, which are reflective of a long history of Eurocentric, patriarchal, colonialist ideologies stemming from the Enlightenment (Twine, 2001; Wrench & Garrett, 2015). The historical values of the Enlightenment permeate the current social structure, which involves an elite ruling over people perceived as regressive, uncivilized, and closer to nature, as well as the concordant devaluation of emotions and embodiment (Tuhiwai Smith, 1999). To counter this hegemonic discourse, practitioner training and education must bring the affective components of clinical practice back to the forefront, and underscore their role in enhancing patient-practitioner communication, practitioner satisfaction, and clinical outcomes (Acebedo-Urdiales et al., 2018). At the same time, it is important to reclaim caring within a theory of critical care rooted in an understanding of power dynamics and social structures (Antrop-González & De Jesús, 2006). Given that the practitioner-patient relationship is fundamentally characterized by a power imbalance, the practitioner’s disproportionate power can potentially “cloud the ability and desire to listen and empathize” (Saulnier, 2020, p. 298). Interventions that involve reflexive exercises
for practitioners to consider their privilege, implicit biases, complicity in oppression, and impact of their own socio-cultural identity on others, can foster a greater commitment to responsibly using power in ways that promote patients’ autonomy and values (Ion et al, 2018; McKivett et al., 2018).

While these efforts to implement social justice in clinical settings are underpinned by an ideological shift away from individualism towards collectivism, individual-level tools of empowerment for patients can be adopted as an adjunct to broader changes in attitudes, practices, and policies. Practitioners’ and patients’ accounts illustrated the importance of patient self-advocacy, or the capacity to access information and represent one’s interests when interacting with healthcare practitioners (Schmidt et al., 2020). The study findings support prior research suggesting that self-advocacy enhances a range of patient health and quality of life outcomes such as greater involvement in their own care, higher satisfaction with clinical interactions, and improvements in disease management and physical health (Martin et al., 2011; Pickett et al., 2010). In this study, larger patients advocated for themselves by challenging clinicians’ assumptions around weight, requesting explanations of suggested treatments, declining to be weighed, bringing up their own concerns, and seeking out alternative practitioners who could provide better care. Likewise, practitioners in the study conveyed the value of teaching patients how to assert their preferences and needs when interacting with other practitioners who displayed weight bias. Given that self-advocacy is a promising method of fostering patient-centred care (Schmidt et al., 2020), interventions with larger patients can provide education about identifying their own needs, understanding their rights from an anti-oppressive framework, critically analyzing and synthesizing the evidence on weight and health, and managing difficult discussions with healthcare providers. However, careful consideration should be taken with
patient self-advocacy training to avoid placing blame on patients who struggle with actively participating in their care, and to account for broader contextual factors that may constrain patients’ agency. Ultimately, individuals’ capacity for self-care and management can only be optimized if “society at large, healthcare policy, healthcare infrastructures and health care professionals alike […] both reflect and promote this orientation” (McWilliam, 2009, p. 284).

8.3 Strengths, Limitations, and Future Directions

The study’s focus on the Canadian context fills an existing gap in the weight stigma research, which has largely been conducted in the United States (see Wu & Berry, 2018 for a systematic overview of studies on weight stigma). Participants were based in Canada, which in contrast to the largely for-profit system in the United States, has a public healthcare system founded on the social value that healthcare is a shared responsibility of both individuals and society (Donnelly & McKellin, 2007). However, neoliberal individualistic ideologies emphasizing the reduction of healthcare costs still hold profound power in the Canadian socio-cultural landscape (Donnelly & McKellin, 2007). Thus, while the nuances between public and for-profit healthcare practice should be recognized and further explored in research, the findings of this study may still have some relevance to other Western neoliberal societies similarly characterized by tensions between individualism and collectivism.

The study specifically focused on practitioner-patient dyads to honour how healing takes place not within the individual patient or the practitioner, but in the in-between space created by the patient-practitioner connection and their relationships with the broader social world (Ingram, 2014; Scott et al., 2008). This emphasis on the relational dynamic aligns with the theory of relational justice, which posits that “human life is always life lived with others, and therefore justice is necessarily a matter of justice in relationship” (Raines, 1989, p. 131). Such healing
relationships can benefit both patients and practitioners, bringing joy and meaning to both, which may in turn ameliorate major challenges in the healthcare system such as practitioner burnout and patient dissatisfaction (Scott et al., 2008). Integrating both perspectives into the analysis allowed for a more holistic account of patient-practitioner interaction, as well as an exploration of the degree of alignment between both parties’ perspectives, and the impact of practitioners’ social justice orientation on the patient experience. In line with a critical realist approach to interviews, I considered the fallibility of interviewees’ accounts, which required me to examine participants’ narratives not only on their own terms but by comparing them to other sources, namely other interviews in this instance (Smith & Elger, 2014). When designing the study, I was mindful of the possibility that practitioners’ best intentions may sometimes be undermined by a healthcare system operating on a neoliberal model of economic efficiency and growth, and a fixation on meeting institutional targets (Sellman, 2011). My findings suggest that patient and practitioner accounts did not always neatly align, but the vast majority of patients showed appreciation for practitioners’ social justice-oriented, patient-centred, and weight-inclusive approaches to care. This research goal of featuring practitioner-patient dyads in turn influenced my recruitment strategy. I began with the recruitment of social justice-oriented practitioners, and then recruited only patients of the practitioners who had already participated in my study. Hence, these patients’ perspectives on obesity may be shaped by their practitioners. To offer another lens into how conceptualizations of weight, health, and social justice are related, future research could recruit larger patients who themselves identify as social justice advocates. Such research would enhance this study’s findings on what clinical practices best serve the needs of larger patients, and contribute to a larger embodied health movement (Brown et al., 2004) that centres patients’ voices in generating new knowledge about health.
Despite efforts to recruit more people of colour, the majority (31 out of 42 participants) of the sample self-identified as White. As outlined above, patient recruitment was limited by practitioner recruitment. The healthcare workforce across a range of professions in Canada remains White dominated and lacking in racial diversity (Jefferies et al., 2019; Mahajan et al., 2021; Vazir et al., 2019). Some practitioners in the study, particularly dieticians, noted that their patient base was primarily White and middle-class. Starting recruitment with patients rather than practitioners may have led to a different demographic composition. Given the racist origins of fat phobia, it is important for future weight-related research to feature the perspectives of non-dominant racial communities when examining the interlocking systems of oppressions. By probing into all participants’ experiences around power, marginalization, and privilege, my study nevertheless maintains critical race theory’s key mandate of putting the spotlight on race consciousness, in order to contest the dominant model of colour-blindness that has obscured the role of structural White supremacy and implicit biases in healthcare (Johnson & Parry, 2015).

Additionally, the majority of the sample was female, with only two patients (both seen by MDs) and five practitioners (four MDs and one dietician) identifying as male. Most weight stigma research has explored the views of female participants, which may be reflective of the association of body weight and dieting with femininity (Bordo, 2004; McPhail, 2009) and the evidence that weight stigma disproportionately affects women in multiple life domains including employment, media, education, and romantic relationships (Fikkan & Rothblum, 2012). While men and women may not experience the tyranny of beauty standards in equal measure, many men are also vulnerable to weight stigma in everyday life and clinical settings, and may experience body fat as “corporeally polluting and emasculating” (Monaghan, 2008, p. 4). Thus, further research on how different genders navigate these complexities around the associations
between fat, masculinity, and femininity, can “augment feminist and fat activists’ efforts to challenge [weight stigma]” (Monaghan, 2008, p. 3).

Theoretically, the study builds on Bhaskar’s (2008) dialectical critical realist philosophy grounded in the idea of “unity-in-difference [to] counter unproductive dualisms between separateness and unity” (Gunnarsson, 2017, p.115). This approach allows us see nature and culture not as dichotomies, “while still relying on a distinction between them” (Gunnarsson, 2013, p.15, emphasis added). The use of a distinction draws on the concept of emergence to describe how an entity is constituted through the powers and properties of other entities while still retaining its own unique powers and properties; thus, nature and culture cannot be reduced to each other (Gunnarsson, 2013). Guided by the notion of corporeal realism, I explored the distinct ontology of participants’ bodies, including a range of “difficult physical realities and embodied pain” (Meleo-Erwin, 2012, p. 397) they experienced and expressed to me. I considered how these narratives were shaped by the social realm, yet avoided socially reductionistic explanations of participants’ embodied experiences. At the same time, I acknowledge that I am after all, writing about the body, which “has its own limitations” (Wagner & Shahjahan, 2015, p. 245). As Perry and Medina (2011) contend, “the body is impenetrable by the means that we have at our disposal – words, ink, page, computer” (p. 64). This means while I can delve into the body’s complexities, my writing will never be able to encompass the entirety of the body as an “instrument of knowledge” (Wagner & Shahjahan, 2015, p. 245) in its own right. Thus, I believe it is critical to maintain epistemic humility towards the uncertainty arising from our incomplete knowledge of the body’s powers and properties. To promote deeper attunement to the material body, future research on weight stigma can incorporate techniques of embodied learning and
knowledge production such as meditation and performance (see Ng, 2005; Wilcox, 2009) into the research design, including the interview process.

The study makes a novel contribution to the literature by shedding light on the positive elements of healthcare practice in relation to weight stigma and social justice. Much of the prior research on weight stigma has illustrated the prevalence of oppressive attitudes and behaviours amongst clinicians, but little is known about whether and how a social justice orientation is able to mitigate implicit bias and structural discrimination. While a critique of the unequal power relations embedded within the health system is an important starting point, I believe that transformation requires us to envision and showcase alternative models of practice that serve the best interests of patients. Patients in this study conveyed that interacting with practitioners who were weight-inclusive and social justice-oriented profoundly impacted their healthcare experience, and facilitated the process of healing from trauma and shame. By featuring the voices of exemplary practitioners and patients who have benefitted from their care, I seek to encourage reflection, dialogue, and action around integrating social justice into clinical practice.

8.4 Conclusion

Using the patient-practitioner interaction as a microcosm, I have explored the interwoven relationships between individual health and broader social, cultural, economic, and political contexts. The critical realist intersectional framework I have used shifts away from a sole exploration of oppression and towards a relational perspective that concurrently examines privilege and oppression (Windsong, 2018). By considering the perspectives of both marginalized and powerful groups, I seek to illuminate the assumptions that people internalize and uphold, and reconceptualize and reshape the power relations between margin and centre (Choo & Ferree, 2010). The findings suggest that although the disease model of obesity
continues to be invoked, other mechanisms such as financial strain, racism, and social exclusion may undermine patients’ health in more significant ways beyond fat accumulation, which raises the question of whether medicalizing obesity serves patients’ best interests. My research makes theoretical contributions to a number of disciplinary areas including the sociology of health, critical obesity studies, critical realism, intersectionality, interpersonal health communication, health promotion, and public health. Generating more dialogue amongst different disciplines can potentially help to overcome the entrenched disciplinary silos within obesity studies, and lead to shared understandings and common visions for social change. The study’s focus on the patient–practitioner dyad makes a methodological contribution to the existing weight stigma literature, which has for the most part featured either patients’ or practitioners’ perspectives. This emphasis on the relational dynamic highlights the importance of viewing self-determination, healing, and justice as “[involving] the active cooperation of others” (Raines, 1989, p. 137). Accordingly, the study underscores the need to integrate micro-level models of empowerment with a macro-level ethics of social justice. The findings also compel patients, healthcare professionals, and the public at large to develop a more nuanced understanding of weight and health, which will potentially inform clinical interactions around weight-related issues and beyond.
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Appendices

Appendix A: Interview Guide for Physicians and Healthcare Practitioners

(A) What does social justice mean to practitioners who identify as social justice advocates?
(B) How do practitioners translate principles of social justice into concrete practices and behaviours when interacting with larger patients?
(C) What are the challenges that practitioners encounter when working with larger patients?
(D) What does social justice mean to larger patients?
(E) How does social justice-informed care shape larger patients’ experience?
(F) How does social justice-informed care shape larger patients’ experience?

1. Can you tell me a bit about what you do and what a regular day at the clinic looks like for you?
2. I understand that you identify as a social justice advocate. Do you think social justice is a norm in healthcare settings in Canada? Why or why not? (A)
3. What is your personal definition of social justice in practice? (A)
4. Can you describe what social justice in practice looks like? How is what you do different from others who do not practice social justice? (B)
5. When did you first learn about social justice? (A)
6. What are some other life experiences that have shaped your understanding of social justice? (A)
7. (If they don’t bring it up first*) Are there any roles outside of being a clinician that have been important in developing this understanding? (A)
8. (Give list of socio-cultural factors) In what ways do you think your social position (socio-cultural factors such as your profession, race, gender, and body type) impacts your interactions with patients? (A) (B)
9. What do you think are the key social challenges patients encounter that affect their health? (B)
10. (If they haven’t listed it*) Some social challenges include social exclusion, racial discrimination, and limited access to resources. How do you feel about asking your patients about these social challenges? (B)
11. (If positive*) How do (or would) you go about having conversations about social challenges? (B)
12. (If negative*) What prevents you from having such conversations? (B)
13. Have you referred patients to other services outside the clinic? If so, which services?
14. I would like to understand your experience dealing with issues related to patients’ body weight. To start off, what are your preferred terms for discussing weight with patients? (A)
15. (If they don’t bring it up themselves*) What are your thoughts on the term obesity?
16. How is the issue of weight typically brought up in your sessions with your patients? (B)
17. Do you discuss strategies for managing their weight? If no, why not? If yes, what strategies did you recommend? How did you suggest such strategies? (B)
18. Have you witnessed weight-based discrimination in the field that you work in? If so, can you give me some examples? How did you respond in such situations? (B)
19. How do you feel about involving larger patients in decisions on their treatment related to weight issues? (B)
20. (If response is positive*) Do you have examples of how you have done so? (B)
21. What are the benefits of adopting a social justice approach when working with larger patients? (B)
22. What healthcare practitioners, if any, do you work with? (B)
23. Which healthcare practitioner(s) do you think is important to consult when dealing with weight-related issues?
24. How important is it to you that the practitioners you work with are advocates of social justice?
25. (If they work in an interdisciplinary team*) How does working in an interdisciplinary team help you meet the needs of larger patients? (B)
26. What do you like about working with larger patients?
27. In your view, what are the unique needs of larger patients?
28. What are the key external challenges (i.e. challenges in the external environment and systems) of practicing social justice when working with larger patients? (C)
29. What are the key internal challenges (i.e. challenges related to your individual capacity) of practicing social justice when working with larger patients? (C)
30. How do you think you can be better supported to care for larger patients? (C)
31. Are you willing to participate as a guest speaker in a workshop on social justice for students in healthcare fields? The key topics covered will include understanding patients’ social context, providing person-centred care, combating fat phobia, and exploring the power dynamics between the clinician and patient.
For email interviews, follow-up questions will only be posed on the second email correspondence.
Appendix B: Interview Guide for Patients

1. I'd like to start off by understanding your experience as a patient at this clinic. Can you tell me a bit about what a typical session at the clinic is like for you?
2. How comfortable did you feel sharing your health concerns with your health practitioner?
3. To what extent were your health concerns addressed?
4. What does being ‘healthy’ mean to you?
5. Have you been referred to other services outside the clinic? If so, which services? How helpful did you find the referral?
6. I want to hear more about your experience dealing with issues related to body weight. To start off, could you tell me what your preferred terms are for discussing your weight with your practitioner?
7. (If they don’t bring it up themselves) What are your thoughts on the term obesity?
8. Do you feel that your weight affects your health in any way? If yes, how so?
9. Has the topic of weight been brought up by your practitioner? If yes, how so?
10. Were you instructed to do anything about your weight? If yes, which strategies for managing your weight were discussed?
11. How did you feel about these discussions?
12. How involved do you feel in decisions surrounding treatment related to your weight?
13. What decisions have you been involved in making?
14. Do you think your weight affects how you are treated at the clinic? How so?
15. (Provide list of socio-cultural factors) Are there any other factors that you feel affects how you are treated at the clinic?
16. (Referring to list of socio-cultural factors) Which of these factors do you feel affects your health concerns? Would you be able to tell me a bit more about how they do so?
17. Did you discuss any of these factors with your healthcare practitioner? If yes, how so?
18. How does your experience with this practitioner compare to past experiences?
19. What do you like most about the care you have received from your healthcare practitioner?
20. What could your health practitioner do to better meet your healthcare needs?
21. As a patient, what do you think are the most important qualities a healthcare professional should possess?
22. What changes would you like to see in the healthcare system?
23. I would like to return to the idea of social justice in healthcare I mentioned earlier. Does this concept mean anything to you? If so, could you tell me what social justice means to you as a patient?
24. How would you know that you were receiving care from someone who practiced social justice? Have you ever experienced that? What did you like/dislike about that?
25. (If the concept doesn’t mean anything) Can you tell me what it means to you to be treated fairly as a patient? How would you know that you were being treated fairly by your practitioner? Have you ever experienced what you described? What did you like/dislike about that?
Appendix C: List of Socio-Cultural Factors

1. Income
2. Housing
3. Education
4. Access to healthcare
5. Access to nutritious foods
6. Access to clean water and working utilities
7. Ethnicity and culture
8. Race
9. Nationality
10. Age
11. Ability
12. Body shape and size
13. Family and other social support
14. Gender
15. Language and other communication capabilities
16. Occupation and job security
17. Sexual orientation
18. Social inclusion (how integrated or isolated you are from others)
19. Social stressors, such as exposure to violence
20. Socioeconomic status
21. Spiritual/religious values
Appendix D: Demographics Survey

1. What gender do you identify as?
   A. Male
   B. Female
   C. Gender non-binary
   D. __________
   E. Prefer not to answer.

2. What is your age?
   A. 18 - 20 years old
   B. 21 – 30 years old
   C. 31 - 40 years old
   D. 41 - 50 years old
   E. 51 - 60 years old
   F. 61 - 70 years old
   G. 70+ years old
   H. Prefer not to answer

3. Which race(s) do you identify with? You may circle more than one category.
   A. Indigenous (e.g., Inuit, Métis)
   B. Arab/West Asian (e.g., Armenian, Egyptian, Iranian, Lebanese, Moroccan)
   C. Black (e.g., African, Haitian, Jamaican, Somali)
   D. Chinese
   E. Filipino
   F. Japanese
   G. Korean
   H. Latin American
   I. South Asian
   J. South East Asian
   K. White
   L. Other
   M. Prefer not to answer

4. Please specify your occupation
   ____________________
5. What is the highest degree or level of education you have completed?
   A. Secondary School
   B. Bachelor's Degree
   C. Master's Degree
   D. Doctoral Degree
   E. Trade School
   F. Other post-secondary certificate
   G. Diploma
   H. Prefer not to say

6. What is your annual income?
   A. Less than $25,000
   B. $25,000 - $50,000
   C. $50,000 - $75,000
   D. $75,000 - $100,000
   E. $100,000 - $125,000
   F. $125,000 - $150,000
   G. $150,000 - $175,000
   H. $175,000 - $200,000
   I. More than $200,000
   J. Prefer not to say
Appendix E: Flyer for Recruiting Patients

Join a research study and help raise awareness about safe and inclusive healthcare settings

Do you self-identify as fat, large, overweight, or having/living with obesity?

Self-identified People of Colour, Indigenous Peoples, women, gender non-binary people, people with disabilities, and those with other intersecting experiences of marginalization are strongly encouraged to participate

Overview
- The study seeks to understand patients’ perspectives on how their social background and body shape and size influence their interaction with healthcare professionals
- Research findings will be used to help health professionals develop an awareness of size-acceptance and social justice

Eligibility criteria
- Patient at this clinic
- Above the age of 18
- Self-identify as fat, large, overweight, or having/living with obesity

What’s involved
- 1 to 1.5 hour one-on-one interview over the phone, Zoom or email
- Upon completion of interviews, you will receive an electronic report of research findings and be invited to offer your comments
- $50 compensation for your time

Sample questions you will be asked
- How involved do you feel in decisions surrounding treatment related to your weight?
- Do you think your weight affects how you are treated in a healthcare setting? How so?
- Are there any other factors (e.g., race, gender) that you feel affects how you are treated?
- What do you like most about the care you have received from your healthcare practitioner?
- What does it mean to you to be treated fairly as a patient?

This research is being conducted for a PhD dissertation under the supervision of Primary Investigator Dr. Laura Hurd. Please contact Deana Kanagasingam at XYZ or at XYZ to find out more or express your interest in participating
Appendix F: Study Information Sheet for Practitioners

Study on Social Justice and Size Acceptance in Healthcare

Overview of research
1) Understand health professionals’ perspectives on social justice and how social justice awareness translates into clinical interactions with larger patients.
2) Understand patients’ perspectives on social justice and how social justice practice shapes larger patients’ experience.
3) Research findings will be used to help other health professionals and trainees develop an awareness of social justice, size-acceptance, and weight-inclusiveness.

Eligibility criteria
- Registered health professional working in Canada
- Self-identifies as an advocate of social justice
- Works with larger patients
- Practice involves weight-related issues

What’s involved
- 1 to 1.5 hour one-on-one interview over the phone, Zoom or email
- Assist with recruitment of patients that you see at your clinic through distribution of e-flyers/pamphlets (please see attached) in clinic space and/or patient electronic mailing list
- Upon completion of interviews, you will receive an electronic report of research findings and be invited to offer your comments. All names and identifying information will be removed from the report and no practitioners will be individually evaluated on their practice.

Sample questions you will be asked
- What is your personal definition of social justice in practice?
- When did you first learn about social justice?
- What are some other life experiences that have shaped your understanding of social justice?
- How did you learn to incorporate social justice into your practice?
- In your view, what are the unique needs of larger patients?

This research is being conducted for a PhD dissertation under the supervision of Primary Investigator Dr. Laura Hurd. Please contact Deana Kanagasingam at XYZ or at XYZ to find out more or express your interest in participating.
Appendix G: Email Introduction to Health Practitioners from Deana

Dear XYZ,

I hope this email finds you well.

I am pursuing a PhD in Kinesiology at the University of British Columbia. My research project “Social justice in the clinic: Caring for larger patients” focuses on how social justice is understood, enacted, and experienced in clinical interactions between healthcare practitioners and larger patients.

I would like to invite you to participate in my study. I read your profile with interest.* Given that you have a social justice orientation and have experience working with larger patients on weight-related issues, I believe you would be able to provide valuable insights on this topic.

Additionally, I would like to understand how the social justice-informed approach that you take shapes your patients’ healthcare experiences. In order to recruit patients, I am requesting for your assistance to post flyers around your clinic space and/or distribute electronic flyers via your patient electronic mailing list. Patients will be invited to contact me directly if they meet the study criteria.

I have attached here an information sheet on the study.

Thank you very much for your time and attention. I look forward to hearing back from you.

Note: this segment will be customized to the practitioners’ profile and may highlight some of the interesting and relevant work that they have done.
Appendix H: Email Introduction to Health Practitioners from Committee Member

Dear XYZ,

I hope this email finds you well.

I would like to introduce you to Deana Kanagasingam, who is pursuing a PhD in Kinesiology at the University of British Columbia under the supervision of Dr. Laura Hurd (Primary Investigator). I am a member of Deana’s PhD dissertation committee. Her research project “Social justice in the clinic: Caring for larger patients” focuses on how social justice is understood, enacted, and experienced in clinical interactions between healthcare practitioners and larger patients.

I would like to invite you to participate in her study. Given that you have a social justice orientation and have experience working with larger patients on weight-related issues, we believe you would be able to provide valuable insights on this topic.

Additionally, Deana would like to understand how the social justice-informed approach that you take shapes your patients’ healthcare experiences. In order to recruit patients, she is requesting for your assistance to post flyers around your clinic space and/or distribute electronic flyers via your patient electronic mailing list. Patients will be invited to contact Deana directly if they meet the study criteria.

I have attached here an information sheet on the study.

Thank you very much for your time and attention. We look forward to hearing back from you.

If you have any questions about the study, please contact Deana at XYZ or at XYZ.

Best wishes,
Bob Woollard
CONSENT FORM

STUDY TITLE:
Social Justice in the Clinic: Caring for Larger Patients

PRIMARY INVESTIGATOR (RESEARCH SUPERVISOR):
Laura Hurd, Professor
School of Kinesiology
The University of British Columbia
Office telephone: XYZ
Email: XYZ

CO-INVESTIGATOR (RESEARCH SUPERVISOR):
Moss Norman, Assistant Professor
School of Kinesiology
The University of British Columbia
Phone: XYZ
Email: XYZ

PRIMARY CONTACT:
Deana Kanagasingam, PhD Candidate
School of Kinesiology,
The University of British Columbia
Phone: XYZ
Email: XYZ

This research is being conducted for a PhD dissertation.
PURPOSE OF THE STUDY:

For this study, I (Deana Kanagasingam) am interested in learning more about your experiences in the healthcare context. In particular, I would like to hear about how your social background, body size and shape influence your encounters with health professionals. In addition to hearing from patients, I will also be speaking with health professionals. This research is important because there is evidence to suggest that discrimination based on body size and shape, as well as race, gender, and class, can negatively impact the healthcare experiences and outcomes of larger patients. My study will fill a research gap by showing an alternative to how obesity is typically treated, which often involves blaming and shaming attitudes and behaviours towards larger patients. The results from this project will be used to develop a training session for healthcare trainees, to help them incorporate social justice into their clinical practice, and subsequently improve patients’ quality of care.

The study is funded by a UBC School of Kinesiology Research Grant.

STUDY PROCEDURES:

You will be interviewed on a platform (i.e. Zoom, phone, or email) of your choosing by Deana Kanagasingam, a graduate student in the School of Kinesiology at UBC. If you choose to conduct your interview via Zoom, please be informed that Zoom servers are located outside of Canada and Zoom stores your name and information regarding your use of the site outside Canada. To protect your privacy, please change your display name to a nickname. You can also turn off your camera and mute your microphone when you are not using them. Further instructions on how to use Zoom will be given in an email reminder sent prior to your interview.

Phone and Zoom interviews will be conducted primarily once with the possibility of follow-up sessions for clarification, whereas email interviews will involve multiple correspondences (approximately two to three) so that I can follow up on your initial responses. The entire interview will take approximately one to 1.5 hours.

You will also be asked to fill in a short survey on your demographic information (e.g., your age, gender etc.). You will have the option to complete the survey in a variety of ways, including online, by telephone, or in a paper version. With your permission, I will record the interview so that I can concentrate on what you have to say rather than on taking notes. Please note that for Zoom interviews, both the audio and video will be recorded, but only the audio file will be used for the transcription and the video file will be deleted.

After the interviews have been completed, you will receive a report of research findings on patients’ and practitioners’ perspectives and be given the chance to offer your comments.
CONFIDENTIALITY:

Your identity will be kept strictly private. Only Deana Kanagasingam and her research supervisors will have access to the audio recordings and study documents, which will be encrypted and password-protected. Your healthcare provider will not have access to any information that will show who you are. The information you provide will only be used for presentations, research reports, and research publications. No names or any information that might show who you are will be used when the results of the study are reported.

Please note that the data (with identifiers removed) may be published on platforms such as e-books or online journals which are made open access to increase the visibility of research. Open access means that the research findings are distributed online to readers without cost or other access barriers.

REMUNERATION:

You will be reimbursed $50 which you can choose to have sent via Internet e-transfer or via a mailed cheque.

RISKS AND BENEFITS:

There is the possibility that talking about weight-based and other forms of discrimination in healthcare settings will bring up some uncomfortable feelings for you. Please feel free to take a timeout and return to questions later, and/or choose not to speak about any experiences that cause too much discomfort. Your contribution will help to raise healthcare practitioners and trainees’ awareness of fair and equitable clinical practices, which may potentially lead to the implementation of changes in practices that improve patients’ quality of care. Although you will not directly benefit from participating in this study, I hope that you will enjoy reflecting on your experiences in healthcare and considering the kind of changes you want to see in the healthcare system.

YOUR RIGHTS:

Your participation in the study is entirely voluntary. You may refuse to answer any question or withdraw from the study at any time without giving a reason and without penalty. If you decide to withdraw from the study at any time, the information you provide will be destroyed and deleted (study documents and audio recordings).
WHO TO CONTACT IF YOU HAVE CONCERNS OR COMPLAINTS?

If you have any concerns or complaints about your rights as a research participant and/or your experiences while participating in this study, contact the Research Participant Complaint Line in the UBC Office of Research Ethics at 604-822-8598 or RSIL@ors.ubc.ca or call toll free 1-877-822-8595.

QUESTIONS?

If you have any questions or want further information about the study, please contact Deana Kanagasingam at XYZ or at XYZ.

**Consent to participate:** I have read and understand the above information and freely consent to participate in this research. I consent to have my interview recorded and to fill in the short demographics survey.

By completing the survey and participating in the interview, I consent to participate in this research project.

Participant's Name: ________________________________________Date: _________
Appendix J: Consent Form for Practitioners

CONSENT FORM

STUDY TITLE:

Social Justice in the Clinic: Caring for Larger Patients

PRIMARY INVESTIGATOR (RESEARCH SUPERVISOR):

Laura Hurd, Professor
School of Kinesiology
The University of British Columbia
Office telephone: XYZ
Email: XYZ

CO-INVESTIGATOR (RESEARCH SUPERVISOR):

Moss Norman, Assistant Professor
School of Kinesiology
The University of British Columbia
Phone: XYZ
Email: XYZ

PRIMARY CONTACT:

Deana Kanagasingam, PhD Candidate
School of Kinesiology,
The University of British Columbia
Phone: XYZ
Email: XYZ

This research is being conducted for a PhD dissertation.

PURPOSE OF THE STUDY:

For this study, I (Deana Kanagasingam) am interested in examining how social justice is understood, enacted, and experienced in clinical interventions related to weight. In particular, I
would like to hear about how your social justice approach influences your encounters with patients. In addition to hearing from healthcare professionals, I will also be speaking with patients. This research is important because there is evidence to suggest that discrimination based on body size and shape, as well as race, gender, and class, can negatively impact the healthcare experiences and outcomes of larger patients. This study fills a research gap by presenting an alternative to the dominant paradigm of obesity treatment, which has often been found to involve blaming and shaming attitudes and behaviours towards larger patients. The research findings will guide capacity-building efforts targeted at healthcare trainees to equip them with clinical skills consistent with a social justice paradigm, and subsequently enrich patients’ quality of care.

The study is funded by a UBC School of Kinesiology Research Grant.

STUDY PROCEDURES:

You will be interviewed on a platform (i.e. Zoom, phone, or email) of your choosing by Deana Kanagasingam, a graduate student in the School of Kinesiology at UBC. If you choose to conduct your interview via Zoom, please be informed that Zoom servers are located outside of Canada and Zoom stores your name and information regarding your use of the site outside Canada. To protect your privacy, please change your display name to a nickname. You can also turn off your camera and mute your microphone when you are not using them. Further instructions on how to use Zoom will be given in an email reminder sent prior to your interview.

Phone and Zoom interviews will be conducted primarily once with the possibility of follow-up sessions for clarification, whereas email interviews will involve multiple correspondences (approximately two to three) so that I can follow up on your initial responses. The entire interview will take approximately one to 1.5 hours.

With your permission, I will record the interview so that I can concentrate on what you have to say rather than on taking notes. You will also be asked to fill in a short survey on your demographic information (e.g., your age, gender etc.). You will have the option to complete the survey in a variety of ways, including online, by telephone, or in a paper version. Please note that for Zoom interviews, both the audio and video will be recorded, but only the audio file will be used for the transcription and the video file will be deleted.

After the interviews have been completed, you will receive a report of research findings on patients’ and practitioners’ perspectives and be given the chance to offer your comments.
CONFIDENTIALITY:

Your identity will be kept strictly private. Only Deana Kanagasingam and her research supervisors will have access to the audio recordings and study documents, which will be encrypted and password-protected. The information you provide will only be used for presentations, research reports, and research publications. No names or information that might show who you are will be used when the results of the study are reported.

Please note that the data (with identifiers removed) may be published on platforms such as e-books or online journals which are made open access to increase the visibility of research. Open access means that the research findings are distributed online to readers without cost or other access barriers.

RISKS AND BENEFITS:

There is the possibility that talking about weight-based and other forms of discrimination in healthcare settings brings up some uncomfortable feelings for you. Please feel free to take a timeout and return to questions later, and/or choose not to speak about any experiences that cause too much discomfort. Your contribution will help to raise healthcare practitioners and trainees’ awareness of fair and equitable clinical practices, which may potentially lead to the implementation of changes in practices that enhance patients’ quality of care. Although you will not directly benefit from participating in this study, I hope that you will enjoy reflecting on your experiences in healthcare and considering the kind of changes you desire in your own practice and the healthcare system.

YOUR RIGHTS:

Your participation in the study is entirely voluntary. You may refuse to answer any question or withdraw from the study at any time without giving a reason and without penalty. If you decide to withdraw from the study at any time, the information you provide will be destroyed and deleted (study documents and audio recordings).

WHO TO CONTACT IF YOU HAVE CONCERNS OR COMPLAINTS?

If you have any concerns or complaints about your rights as a research participant and/or your experiences while participating in this study, contact the Research Participant Complaint Line in the UBC Office of Research Ethics at 604-822-8598 or RSIL@ors.ubc.ca or call toll free 1-877-822-8595.
QUESTIONS?

If you have any questions or want further information about the study, please contact Deana Kanagasingam at XYZ or at XYZ.

**Consent to participate:** I have read and understand the above information and freely consent to participate in this research. I consent to have my interview recorded and to fill in the short demographics survey.

By completing the survey and participating in the interview, I consent to participate in this research project.

Participant's Name: ___________________________ Date: _________
### Appendix K: Codebook

<table>
<thead>
<tr>
<th>Categories - Practitioners</th>
<th>Themes</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical consciousness</td>
<td>An awareness of the simultaneous experience of privilege and marginalization around one’s social identity and positioning, such as race, class, gender, occupation and body type, amongst others.</td>
<td>• White privilege, thin privilege, class privilege • Patient-practitioner power imbalance • Using privilege wisely • Working through the ingrained idea that obesity is bad • Cultural sensitivity • Cultivating compassion through personal experience with discrimination and trauma • Acknowledging and examining blind spots and biases • Admitting what they do not know • Willingness to learn</td>
</tr>
</tbody>
</table>

Navigating between additive and interactive understandings of intersectionality, which refers to seeing multiple social oppressions as cumulative or intertwined, respectively.

Integrating the micro and macro refers to addressing macro issues of injustice and
inequity through micro-level interactions

**Straddling the line between equity** (or treating people based on their needs and abilities) and **equality** (or treating everyone the same)

- Self-disclosure about one’s own struggles and experiences with patients
- Experiences of racism, sexism, homophobia, and sizeism (larger bodied practitioners faced pressures to embody thin ideal)
- Finding common ground with patients
- Weight-based discrimination equivalent to other kinds of discrimination
- Weight-based discrimination rooted in other kinds of discrimination
- Individual empowerment and healing are not enough without broader societal changes
| Individual behaviours such as nutrition and exercise must be situated within the broader context |
| Understanding the role of diet culture |
| Asking patients about social challenges |
| Implementing strategies to alleviate social challenges |
| Social justice in clinical practice differentiated from political activism |
| Advocacy work outside of clinical practice |
| Equal access to care |
| Treating all patients equally |
| People do not start of same playing field |
| Person-centred and person-directed care refer to focusing on the whole person rather than just their medical conditions(s) and positioning the individual to assume control of decisions surrounding their care | \begin{itemize}
  
  \item Emphasizing compassionate care and narrative competence, which refers to the ability to elicit, acknowledge, understand, and act on patients’ narratives to create a sense of emotional safety and connection
  
  \item Displaying curiosity about patients’ lives beyond their presenting medical issues, particularly asking difficult questions to help uncover underlying needs and concerns
\end{itemize} | \begin{itemize}
  
  \item Unique needs of larger patients
  
  \item Equity and equality used interchangeably
  
  \item Empathic listening
  
  \item Non-judgment
  
  \item Sensitivity
  
  \item Curiosity about patients’ world (asking difficult questions)
  
  \item Challenges of asking questions (Time constraints; fear)
  
  \item Gently challenging patients’ perspectives
  
  \item Maintaining professionalism while standing up to other healthcare professionals
  
  \item Obtaining consent
  
  \item Placing patient in driver’s seat
\end{itemize} |
| **Centering patients’ own wisdom about their conditions, and positioning them as the experts in their own care** | • **Shared decision-making**  
• **Uncovering and leveraging on patients’ strengths**  
• **Meeting patient where they are at/ tailoring care to patients’ needs**  
• **Speaking in patient’s language (in a way that they can understand, using terms they prefer)**  
• **Collecting feedback**  
• **Working in interdisciplinary teams**  
• **Referring patients to other healthcare practitioners**  
• **Tapping on other community services**  
• **Challenges of making referrals (not sure who to refer to)** |

**Advocacy** refers to increasing patients’ capacity to access information and represent their interests when interacting with healthcare practitioners.

**Interprofessional collaboration and community linkages** is based on the belief that patients’ complex health needs cannot be addressed by each professional in silos and requires collaborative effort across professions and with community resources.

- **Shared decision-making**
- **Uncovering and leveraging on patients’ strengths**
- **Meeting patient where they are at/ tailoring care to patients’ needs**
- **Speaking in patient’s language (in a way that they can understand, using terms they prefer)**
- **Collecting feedback**
- **Working in interdisciplinary teams**
- **Referring patients to other healthcare practitioners**
- **Tapping on other community services**
- **Challenges of making referrals (not sure who to refer to)**
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<tr>
<th>Fighting against a culture of weight-based discrimination in healthcare and beyond</th>
<th>Covert discrimination refers to more subtle forms of discrimination such as larger patients being told that weight was the cause of their problems</th>
<th>Overt discrimination refers to an explicit display of discrimination such as larger</th>
</tr>
</thead>
<tbody>
<tr>
<td>(covert) Other practitioners weighing patients and measuring their BMI</td>
<td>(covert) Other practitioners making assumptions about patients’ diet, lifestyle, choices</td>
<td>(covert) Other practitioners</td>
</tr>
</tbody>
</table>

- Highlighted important role of mental health professionals
- Practitioners were careful about whom they referred patients to
- Tread carefully when challenging other practitioners
- Experience pushback/difficulties with other practitioners
patients being ridiculed for their weight

**Weight inclusiveness and social justice are still fringe movements in healthcare,** and many patients and practitioners perceived weight-inclusive practitioners as being the exception in a healthcare system that continues to fixate on weight management

congratulating patients for losing weight
• (overt) Other practitioners disbelieving what patients say about their diet and exercise habits
• (overt) Other practitioners denying patients treatment because of their weight
• Weight-inclusive practitioners are rare
• Actively seeking out weight-inclusive practitioners

| Attitudes towards weight and health exist on the continuum with often overlapping perspectives. These attitudes refer to the diverse perspectives | Health as a multifaceted construct beyond weight which refers to how patients define health in terms of physical, emotional, social and mental dimensions | • Grappling with weight-related terminology • Undoing damage from other practitioners |
that practitioners held on
body weight and its
association with health, as
well as their preferred
terminology around weight

| **Healthy skepticism about weight management** is the view that the connection between weight and health is not as straightforward as depicted by the dominant biomedical perspective |
| **Fat acceptance** has overlap with the healthy skepticism perspective but is an explicitly political stance that strives to reclaim the term fat and deconstruct the discourse of obesity |
| **Obesity is a disease** that poses health risks and should be addressed. Weight and health have some connection though it is more important to change health behaviours |

| • Practitioners sometimes felt alienated, isolated, helpless |
| • Practitioners were careful about whom they referred patients to/seeking out like-minded practitioners |
| • Shift focus from weight management to pursuing health goals |
| • Weight is not necessarily linked to health |
| • Unclear how much exactly weight influences health |
| • Accept some medical terms, and reject others |
| • Uncovering fat phobia and desire for weight loss |
| • Obesity is a pathologizing term |
| and address health concerns rather than focus solely on controlling weight | • Ethical stance against weight loss  
• Reclaiming fat (but not straightforward process)  
• Fighting fat oppression supersedes any kind of weight management  
• Strongly opposed to term obese  
• Others are uncomfortable with the term fat  
• Helping patients develop freedom around food and their bodies  
• Obesity should be recognized as a disease  
• Do not use term obese in front of patients (recognition that it is stigmatizing yet subscribes to obesity model) |
- Healthy weight loss is possible
- Non-judgmental approach to weight loss
- Move from shame toward compassion to help weight management
- Weight loss is the natural byproduct of behaviour changes

<table>
<thead>
<tr>
<th>Themes/Categories - Patients</th>
<th>Themes</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical consciousness</td>
<td>An awareness of the simultaneous experience of privilege and marginalization around one’s social identity and positioning, such as race, class, gender, occupation, and body type, amongst others</td>
<td>Desire for practitioners to acknowledge patients’ history of oppression</td>
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<tr>
<td></td>
<td></td>
<td>• Practitioners’ thin privilege is a barrier/unable to relate</td>
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<tr>
<td></td>
<td></td>
<td>• More comfortable with larger bodied practitioners/practitioners with similar experiences</td>
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<tr>
<td>Navigating between additive and interactive understandings of intersectionality, which refers to seeing multiple social oppressions as cumulative or intertwined, respectively</td>
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<td>Integrating the micro and macro refers to addressing macro issues of injustice and inequity through micro-level interactions</td>
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<td>Straddling the line between equity (or treating people based on their needs and abilities) and equality (or treating everyone the same)</td>
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<tr>
<td>• Appreciated when practitioners disclosed their own struggles around weight</td>
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<tr>
<td>• Too much self-disclosure overshadowed patient experience</td>
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<tr>
<td>• Patients highlighted the numerous ways in which they were privileged, particularly because of gender and class.</td>
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<td>• Wanted patients’ social context to be recognized</td>
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<td>• Downplayed weight-based discrimination because of other privileges/oppression as a hierarchy</td>
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<td>• Difficulty bringing up social challenges with practitioner</td>
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<tr>
<td>Person-centred and person-directed care refer</td>
<td>Emphasizing compassionate care and</td>
<td>Non-judgment towards patient/non-judgmental</td>
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<td>• Weight-based discrimination equivalent to other kinds of discrimination</td>
<td>• Emphasizing equal access to care</td>
<td>• Acknowledging people do not start of same playing field</td>
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<tr>
<td>• Weight-based discrimination rooted in other kinds of discrimination</td>
<td>• Treating all patients equally</td>
<td>• Practitioners need to use power responsibly</td>
</tr>
<tr>
<td>• Expressing unique needs</td>
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to focusing on the whole person rather than just their medical conditions(s) and positioning the individual to assume control of decisions surrounding their care

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<th>narrative competence, which refers to the ability to elicit, acknowledge, understand, and act on patients’ narratives to create a sense of emotional safety and connection</th>
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<td><strong>Displaying curiosity</strong> about patients’ lives beyond their presenting medical issues, particularly asking difficult questions to help uncover underlying needs and concerns</td>
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<td><strong>Centering patients’ own wisdom about their conditions, and positioning them as the experts in their own care</strong></td>
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<th>approach towards weight loss</th>
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<tr>
<td>• Empathic listening</td>
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<tr>
<td>• Practitioner displaying curiosity about patients’ lives</td>
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<tr>
<td>• Practitioner drawing on patients’ strengths</td>
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<tr>
<td>• Practitioners’ accuracy of knowledge</td>
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<tr>
<td>• Practitioner gently challenging patient</td>
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<td>• Patient in driver’s seat</td>
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<td>• Patient positioned as expert</td>
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<tr>
<td>• Patient involved in shared decision-making</td>
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<td>• Practitioner meeting patient where they are at/ Tailoring care to patients’ needs</td>
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<td>• Empowered to stand up for oneself</td>
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<td></td>
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- Having health concerns addressed by interdisciplinary teams
- Lack of coordination between healthcare professionals
- Referrals to other healthcare practitioners
<table>
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<tr>
<th><strong>healthcare and beyond</strong></th>
<th>larger patients being told that weight was the cause of their problems</th>
<th>patients and measuring their BMI</th>
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<tr>
<td>refers to the discriminatory practices in healthcare and other social institutions that patients had to continually push back against.</td>
<td><strong>Overt discrimination</strong> refers to an explicit display of discrimination such as larger patients being ridiculed for their weight</td>
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<td><strong>Enjoyment</strong></td>
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<td><strong>Mindfulness</strong></td>
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<td><strong>Emotional/mental health is central</strong></td>
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<td><strong>Functionality (participate in day-to-day activities)</strong></td>
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<td></td>
<td><strong>Appreciated a shift in focus from weight management to pursuing health goals</strong></td>
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<td></td>
<td><strong>Unsure about weight-health connection</strong></td>
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<td></td>
<td><strong>Averse to the term obese but more receptive to other medical terms such as overweight</strong></td>
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<td></td>
<td><strong>Deferred to medical professionals</strong></td>
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</tbody>
</table>
and deconstruct the discourse of obesity

**Obesity is a disease** that poses health risks and should be addressed. Weight and health have some connection though it is more important to change health behaviours and address health concerns rather than focus solely on controlling weight

- Fat is a neutral and non-political term (neither like nor dislike the term)
- Fat is embedded with too much baggage to be reclaimed
- Obesity is a pathologizing term
- BMI is inaccurate
- Anti-diet culture/weight loss
- Fat is a positive term
- Reclaiming fat
- Others are uncomfortable with the term fat
- Fat acceptance is a process
- Fat phobia, not fat, affects health
- Weight is connected to health
- Medicalizing obesity shifts blame away from patient
- Destigmatize obesity
- Obesity is a disease
- Obesity is a neutral term
- Weight loss as desired outcome but not primary goal
- Weight loss is the natural byproduct of behaviour changes
- Healthy weight loss is possible
- Non-judgmental approach to weight loss
- Obese better than fat because of past trauma
- Move from shame toward compassion