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Obesity, heuristic reasoning and the organisation of communicative embarrassment in diagnostic radiography

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ABSTRACT

This paper, the second of three arising from a broader qualitative study, explores difficulties emerging around radiographer-patient communication regarding obesity in hospital-based encounters, and the situated strategies found by experienced radiographers for handling such situations. Semi-structured interviews with eight clinicians working in plain radiography (mean experience = 21.56 years) were analysed using Interpretative Phenomenological Analysis (IPA), so as to highlight the practical, nuanced and real-world experiences of these individuals regarding obesity communication. Participants generally viewed communicating with obese patients as a potential interpersonal 'minefield'. Most reported having had negative experiences in which patients had acted with denial or outright aggression during examinations but, conversely, all reported cases in which patients had been frank and open about their obesity, and even been happy to joke about it. Equally, all participants were able to document a range of communicative strategies for effectively handling potentially difficult situations. Results further indicate that the documented communicative problems and embarrassment for the patient only generally arose within specific material contexts; i.e. when equipment is inadequate or multiple exposures are necessary. It is concluded that, while participants largely expected any interaction about obesity with a patient to be embarrassing for both parties, their actual experience was much more varied. This indicates a more complex communicative environment than may be expected, and also a potential metacognitive availability heuristic in play – something that might be clarified with future quantitative investigation.

Introduction

According to the World Health Organisation (WHO), worldwide obesity rates have more than doubled since 1980, reaching 'epidemic' proportions by 1997, particularly in the Western world.[1] In the United Kingdom (UK), from which the data used in this paper emerge, and as noted in current National Health Service (NHS) guidelines on 'Identification, assessment and management of overweight and obesity in children, young people and adults',[2] over one quarter of all adults were classed as clinically obese by 2013. This upward trend is placing increasing pressures on national healthcare systems[3] in two key ways. Firstly, the corollary increases in rates of associated comorbidities, such as coronary heart disease, osteoarthritis, diabetes mellitus and respiratory problems increase the overall number of individuals requiring care.[4] Secondly, and more pertinent to the primary material addressed here, the everyday management of obese patients in practical healthcare can create further workload-escalating problems for clinicians, not least in medical imaging departments.[5]

Recent research has reported a range of relevant difficulties for radiographers. The most commonly observed emerge around precise imaging itself, whereby decreased penetration of X-rays through high levels of subcutaneous fat, intra-abdominal fat deposition, and other obesity-related changes in soft tissue structures, can result in the need for repeat projections, the need to image in quadrants, higher recall incidences and increased biopsy rates.[6–8] On a more practical, everyday level, the manual handling of obese patients also has implications for clinical practice in a range of ways. Positioning such an individual so as to effect diagnostically-satisfactory results can be awkward and time-consuming, sometimes requiring extra staff, multiple image receptors and particular attention to the patient's respiration and general comfort.[5,9–11]

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There remains, however, a serious scarcity of research exploring how affected clinicians in-the-field actually communicate with obese patients, and particularly how they handle attendant matters of stigma and embarrassment (both for the patient and themselves). There is an abundance of work in the broader healthcare sciences relating to professional-patient communicative encounters around a variety of nominally difficult topics, such as mental illness,[12,13] HIV,[14] and, indeed, obesity itself.[15–17] Within radiography there has been some valuable investigation of general practitioner-patient communication, typically using transactional analysis,[18,19] but little published literature has emerged to date regarding the specific management of difficult communicative matters. Using Interpretative Phenomenological Analysis (IPA),[20] therefore, this paper reports communication-specific findings arising from a broader qualitative study of the impacts of patient obesity upon the working lives of experienced diagnostic radiographers working in the NHS.

Methods

IPA is centrally ordered to qualitatively describe the complex ways in which individuals make sense of their own experience, and in medical fields has thereby encouraged a focus upon the acquired 'soft skills' of practitioners and patients as used in specific contexts, and with respect to specific procedures.[20,21] As such, the approach builds an evidence-base from real clinical experiences, rather than legislating from common-sense or idealised deductive assumptions regarding what constitutes best practice.[13,22]

Participants

Established studies in medical IPA typically use small and relatively homogeneous populations to elucidate the relationship between healthcare cultures and the social psychological experiences of individuals involved therein.[21] With full institutional ethical approval, eight experienced diagnostic radiographers were interviewed (mean years in practice = 21.56), recruited from four different NHS hospitals in the North West of England.

Procedure

Consistent with the IPA approach,[20] semi-structured interviews were used and core issues for discussion were posed as simply and openly as possible, to encourage free discourse around the topic at hand. These issues are summarised in Table 1:

Further minor prompts were used to encourage elaboration where pertinent, as is standard in IPA data collection.[20] Each interview was captured using a digital voice recorder and transcribed verbatim. As required by institutional ethical mandate, all data were rendered anonymous during transcription, and all participants were allotted labels based on the order in which the interviews took place (i.e. 'R1, 'R2' etc.) when connected to any given quotation in the results. The mean interview length was 30 min.

Table 1
Core interview schedule.

Core question	Major prompts
Could you give me an overview of the main problems that patient obesity has caused in your professional role?	• How did it affect the process? • How did it affect you? • How did it affect the patient? • Can you provide examples?
How did you handle these situations?	• What worked and what didn't? • Can you provide examples?

Analysis

Analysis was manually conducted in line with the standard methods of IPA. Raw textual codes were collected into linked (subordinate) themes, and then formulated into master (superordinate) themes that maintained form across the full corpus of data.[23] The original study yielded four superordinate themes, of which "Communication and Stigma" was one; in terms of participants' own discursive focus, however, communication was the single matter of greatest concern and is, thus, handled as a singular issue here. A parallel paper, addressing two further superordinate themes (pertaining to the organisational and material/technological aspects of handling obese patients) is available elsewhere.[23] A paper addressing implications around the final theme – everyday diagnostic challenges – is, at time of writing, in preparation. This methodologically-appropriate division of dissemination was explicitly permitted within the conditions of ethical approval.

Trustworthiness

As recommended by Yardley,[24] the character of the provisional analysis was determined through consistent discussion and review of data by all four authors[1] until consensus was reached. *Impact and importance* was tested by presenting this provisional work at a major radiological conference; peer feedback arising from this presentation was then utilised to fine-tune the analysis for publication. *Transparency and coherence* are, ideally, evident in the close correspondence between presented data and claims advanced.

Results

The issue of Communication and Stigma is addressed in terms of its two core subordinate aspects.

The radiographer – anxiety, professionalism and social experience

When discussing patient obesity in general, all participants broadly argued that such interactions had simply been a communicative 'minefield' for them at times, and that this often led them to expect that raising the issue would be embarrassing for both them and their patient. As such, they approached any such situation with trepidation regarding what to say or, more specifically, how to say it. For example, with respect to the contexts of repeat projection and table weight limit.

> **R2:** *"If they are obese and approaching that [table] limit, having to explain to them that you might need to be waiting for the only room that will take the excess weight on the table. [A]nd how to approach that without appearing to discriminate against the patient?"*

The anxiety that a radiographer can experience around such scenarios is typified in the following account:

> **R6:** *"[I]t's this thing of social embarrassment… and actually we're embarrassed to bring the subject up…I suppose of things that didn't work in terms of communication was actually our comfort with it, and if maybe we had a set way of dealing with it, a sort of, almost an algorithm of doing something like that, that [made it] acceptable to discuss issues of weight with patients."*

[1] One junior radiographer, two experienced professional and academic radiographers, and one veteran medical researcher with no core background in professional radiography. This diversity allowed for a range of interpretations of the given data.