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Managing social awkwardness when caring for morbidly obese patients in intensive care: A focused ethnography

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ABSTRACT

Background: Critically ill morbidly obese patients pose considerable healthcare delivery and resource utilisation challenges in the intensive care setting. These are resultant from specific physiological responses to critical illness in this population and the nature of the interventional therapies used in the intensive care environment. An additional challenge arises for this population when considering the social stigma that is attached to being obese. Intensive care staff therefore not only attend to the physical and care needs of the critically ill morbidly obese patient but also navigate, both personally and professionally, the social terrain of stigma when providing care.
Aim: To explore the culture and influences on doctors and nurses within the intensive care setting when caring for critically ill morbidly obese patients.
Design and methods: A focused ethnographic approach was adopted to elicit the 'situated' experiences of caring for critically ill morbidly obese patients from the perspectives of intensive care staff. Participant observation of care practices and interviews with intensive care staff were undertaken over a four month period. Analysis was conducted using constant comparison technique to compare incidents applicable to each theme.
Setting: An 18 bedded tertiary intensive care unit in New Zealand.
Participants: Sixty-seven intensive care nurses and 13 intensive care doctors involved with the care and management of seven critically ill patients with a body mass index $\geq$40 kg/m^2.
Findings: Interactions between intensive care staff and morbidly obese patients were challenging due to the social stigma surrounding obesity. Social awkwardness and managing socially awkward moments were evident when caring for morbidly obese patients. Intensive care staff used strategies of face-work and mutual pretence to alleviate feelings of discomfort when engaged in aspects of care and caring. This was a strategy used to prevent embarrassment and distress for both the patients and staff.
Conclusions: This study has brought new understandings about intensive care situations where social awkwardness occurs in the context of obesity and care practices, and of the performances and behaviours of staff in managing the social awkwardness of fat-stigma during care situations.

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What is already known about the topic?

- Obesity is a highly stigmatised condition.
- Caring for morbidly obese patients is both physically and socially challenging for health professionals.
- Weight-bias and fat-stigma have been reported as an issue in health care provision.
- Research has focused on self-reported attitudes and behaviours.

What this paper adds

- Interactions between intensive care staff and morbidly obese patients are socially challenging due to the social stigma surrounding obesity.
- When intensive care staff interact with morbidly obese patients feelings of anxiety and discomfort arise.
- As a result health professionals experience social awkwardness when providing care to morbidly obese patients.
- Managing socially awkward moments is an emergent dimension of caring for morbidly obese patients.

1. Introduction

Obesity has become a common condition in many countries, and a major concern for public health (Ministry of Health, 2004; Sassi, 2010). The World Health Organisation (2000) identified obesity as one of the most significant world-wide health problems of today, affecting three times more people than 20 years ago. Obesity is a particular concern in New Zealand where, since the late 1980s the prevalence of New Zealand adults who are obese has increased from 10% (Ministry of Health, 2004) to 31% over eleven years (Ministry of Health, 2015). Obesity rates are significantly higher among New Zealanders who are living in socio-economically deprived areas and are of Māori or Pacific ethnicity (Ministry of Health, 2015).

Morbid obesity, a BMI greater or equal to 40 kg/m^2 is the fastest growing category of obesity in developed countries (Bromley and Given, 2011; Grieve et al., 2013; Ministry of Health, 2004). Between 1977 and 2003, morbid obesity in New Zealand increased from 0.32% in males and 1.17% in females to 2.15% and 2.95%, respectively, with the most rapid growth occurring after 1997 (Ministry of Health, 2004). This is consistent with other developed Organisation for Economic Co-operation Development countries where morbid obesity prevalence has tripled over the last three decades and affects approximately 3% of the population (Bromley and Given, 2011; Shields et al., 2011; Tjepkema, 2008).

Morbidly obese patients who are critically ill place unique demands on intensive care services as they are more likely to require prolonged mechanical ventilation and tracheostomy tube placement (Villavicencio et al., 2007; Westerly and Dabbagh, 2011); have increased length of intensive care stay (Martino et al., 2011; Oliveros and Villamor, 2008; Sakr et al., 2012; Westerly and Dabbagh, 2011) increased respiratory and wound complications (Villavicencio et al., 2007; Yaegashi et al., 2005) and require significantly increased staffing support and specialist bariatric equipment (Winkelman and Maloney, 2005).

Challenges in the care of morbidly obese patients in the intensive care unit (ICU) are not limited to physiological and resource-based problems. There is concern that the attitudes and beliefs of healthcare professionals about obesity may impact on relationships between healthcare professionals and morbidly obese patients, and on the quality of care that these patients receive (Merrill and Grassley, 2008; Mold and Forbes, 2013). Although there is self-reported evidence that healthcare professionals hold more negative attitudes towards morbidly obese patients compared with normal weight patients (Schwartz et al., 2003), little is known about how doctors and nurses engage and interact with morbidly obese patients during care provision within hospital settings. The nature and quality of interactions during actual care practices remains mainly unexplored. This paper reports on findings of a study that explored the culture and influences on doctors and nurses within the intensive care setting when caring for critically ill morbidly obese patients.

2. Methods

2.1. Study design

A focused ethnographic approach was adopted as the design for this study enabling the exploration of a distinct issue or shared experience within a culture and in specific settings, rather than throughout entire communities (Cruz and Higginbotton, 2013; Fetterman, 2010; Higginbottom et al., 2013). This approach enabled the study's aim of understanding 'situated' experiences in the professional culture of intensive care staff caring for a subgroup of patients that were morbidly obese, to be met. Ethnographic methodological principles and methods guided data collection, analysis and the written representation of the social group researched.

This study adopted an insider perspective as the ICU was the primary researcher's (CH) place of work, and had been for the previous seven years. The insider position is usually adopted by nurse researchers who are not only researching their own specialty practice areas of nursing but also their own workplace and colleagues (Asselin, 2003; Cudmore and Sondermeyer, 2007; Griffiths, 2008; Simmons, 2007). In these instances, nurse researchers are familiar with the setting and specialty knowledge of the daily routines of the place, and of the research participants prior to engaging in the study. This knowledge and pre-existing relationships are used to inform fieldwork.

2.2. Sampling and recruitment

The setting for this study was an 18 bedded tertiary ICU in New Zealand. Participants were ICU staff who cared for morbidly obese patients in this unit. All ICU staff within the unit were involved in the study unless they chose not to consent to participate. Staff caring for patients with a BMI $\geq$40 kg/m^2 (i.e. were morbidly obese), who were not undergoing weight loss (bariatric) surgery and expected to remain in the unit for more than 12 h were observed. Staff