WEIGHT-RELATED MESSAGES IN PRIMARY CARE:
CHALLENGES AND POSSIBILITIES

by

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ABSTRACT

The purpose of the present study was to acquire a detailed understanding of women’s experiences receiving weight-related information or advice from their general practitioners (GPs). Guided by a critical feminist perspective, this qualitative study explored cultural and social processes that interact with women’s understanding and perceptions of weight-based dialogues. In-depth interviews about weight-related care were conducted with 18 women between the ages of 18 and 45. The women varied in terms of social locations, ethnicity, sexual orientation, socioeconomic status, and body sizes and weight. A constructivist grounded theory methodology was used to analyse the transcribed interviews.

Three core categories emerged in the data analysis in relation to the women’s experiences, namely: (1) Weight Weighing on the Doctor-Patient Relationship, which highlighted the ways weight-based dialogues affected the doctor-patient relationship; (2) Patients’ Self and Body Experiences, which focused on women’s ongoing struggles with weight in relation to sociocultural pressures, as well as how these experiences shaped women’s responses to weight-based care; and (3) Practice, which revealed the weight-management practices of GPs, and constructive insights regarding ways in which GPs’ practices could be improved. The intricacies revealed herein can help inform GPs in navigating the complexities of providing sensitive, weight-related interventions, while simultaneously enhancing the doctor-patient relationship and the quality of care received.
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DEDICATION

This dissertation is lovingly dedicated to my grandparents,
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Your unconditional love, faith, and wisdom have been instrumental in shaping the person I am today. You have instilled in me a joy of learning, a compassion for others, and most importantly, a true understanding of the art of healing.
CHAPTER ONE
INTRODUCTION

The 2006 Canadian Clinical Practice Guidelines on the Management and Prevention of Obesity in Adults and Children recommend that general practitioners (GPs), given their role in front-line care, provide lifestyle counselling during yearly physical examinations (Lau et al., 2007). Congruently, research indicates that many GPs communicate a high awareness of obesity as a medically pertinent concern and perceive weight-management interventions as part of their responsibilities (Kristeller & Hoerr, 1997). However, GPs often report feeling under-trained in this particular area of care (Bocquier et al., 2005), and outcomes of obesity management remain poor (Heintze et al., 2010). The concept of body size being equated to a particular “health” status—also known as the medicalization of obesity—has resulted in a narrowing of tolerance toward those who are overweight or obese (Conrad, 1994). Individuals who are overweight or obese are subject to multiple forms of prejudice, discrimination, and stereotypical attribution (Burns & Gavey, 2004). Furthermore, labels attached to obesity and obese individuals are far worse and more frequent for females (Puhl & Heuer, 2009).

Obesity stigmatization is also prevalent in the medical community (Bocquier et al., 2005). Research illustrates that many health care professionals hold implicit negative attitudes and morally laden interpretations regarding weight (e.g., Foster et al., 2003; Mold & Forbes, 2013; Olson, Schumaker, & Yawn, 1994). Accordingly, variables such as these create a complex environment for the provision of weight-management directives provided by GPs, as well as for patients involved in these dialogues. To date, GPs have received little guidance on how to address health and weight concerns with
patients in a constructive and sensitive manner. Further, there is a dearth of research pertaining to patients’ experiences with doctors’ weight-related dialogues in relation to the Canadian culture and medical care system, especially in light of the important intersections of multiple social factors in shaping women’s experiences with doctors and weight. In order to better inform and support physicians, a holistic representation of women’s lived experiences, both inside and outside the medical environment, must be explored.

To account for these shortcomings, the current study adopted a critical feminist perspective to provide a detailed and rich depiction of women’s experiences as recipients of weight-related care. Emphasis was given to women’s past and present experiences with weight and body practices, as well as their unique social locations, which proved influential in shaping weight-related interactions with their GPs. Semi-structured qualitative interviews were conducted to explore women’s experiences. More specifically, the present study invited women to describe their reactions to weight-related practices from their GPs within the context of their lives, and to reflect upon their values regarding weight and health in relation to their doctors. In doing so, this study offered a unique exploration into the complexity of weight-related exchanges in the doctor-patient relationship, and the ways in which women’s ongoing lived experiences with body size and weight shape their responses to doctors’ weight-based care.
LITERATURE REVIEW

The Focus on Obesity

Today’s trend in the medical community is to describe obesity as a health problem of epidemic proportions (Beaudoin, Lussier, Gagnon, Brouillet, & Lalande, 2001). In Canada over the past 25 years, the number of individuals who are overweight or obese has increased dramatically (Lau et al., 2007). According to the 2004 Canadian Community Health Survey, 59% of the Canadian adult population is overweight (BMI 25 to 29.9) and 23% are obese (BMI ≥ 30), which is nearly a 10% increase since 1978/79 (Shields, 2005). Moreover, particular subgroups of the population are at even greater risk for being overweight or obese, including women, ethnic minorities, and individuals from lower socioeconomic statuses (e.g., Ogden et al., 2006; Raine, 2004; Valdez & Williamson, 2002).

Perspectives on Weight

The etiology of obesity involves complex interactions between many variables including environmental, genetic, physiologic, psychological, social, and economic factors (Aronne, Nelinson, & Lillo, 2009). Numerous disciplines have provided distinct angles of inquiry regarding overweight and obese bodies. For example, the medical community often highlights the health-related risks associated with obesity, as well as views on appropriate and effective treatments (Aronne, 2001); feminist perspectives frequently address the harmful messages associated with quantifying health and the detrimental weight-based stigma linked to overweight bodies (Bordo, 1993); and popular culture frequently saturates society with weight-preoccupied messages regarding thinness.
and femininity, as well as “quick fixes” to attain the “perfect body” that are supported by a multi-billion-dollar weight-loss industry (Goodman, 1995).

**Medical Concerns Regarding Obesity**

Obesity has long been associated with significant morbidity and mortality, and numerous health issues have been linked with, or exacerbated by obesity (World Health Organization, 2000). The number of health concerns related to increasing body weight is substantial. Individuals who are overweight or obese are reported to be at higher risk of heart attack, stroke, arthritis, Type 2 diabetes mellitus, hypertension, dyslipidemia, breast cancer, colon cancer, gallbladder disease, polycystic ovary syndrome, osteoarthritis, and sleep apnoea, to name but a few (Kopelman, 2007). Accordingly, obesity has been proclaimed a chronic disease, predominant in both developed and developing countries, affecting children as well as adults, and has even exceeded the more traditional significant contributors to ill health including undernutrition and infectious disease (World Health Organization, 2000). Many of these health risks begin to appear in children and young individuals (Kopelman, 2007), and of increasing concern is the rising prevalence of Type 2 diabetes seen in children (Lobstein & Leach, 2004).

Several measurements have been developed in order to quantify obesity and provide a common language for medical professionals. One of the more commonly used measures of body fat is the BMI classification system (Burkhauser & Cawley, 2008). First developed by the World Health Organization Obesity Task Force, the BMI classification system is an approximate measure of body fat, formulated by weight in relation to height (Keys, Fidanza, Karvonen, Kimura, & Taylor, 2014). Health Canada
(2011), in their Canadian Guidelines for Body Weight Classification in Adults, organizes BMI ranges in the following way: Underweight (BMI \( \leq 18.5 \)); Normal Weight (BMI 18.5 to 24.9); Overweight (BMI 25 to 29.9); Obese (BMI \( \geq 30 \)). The BMI measurement has been used in a number of epidemiologic studies, as well as in clinical practice, to track and monitor weight control. Furthermore, BMI statuses are used to communicate associated health risks and recommendations for treatment (Seidell, Kahn, Williamson, Lissner, & Valdez, 2001). An individual’s BMI can be quickly computed and has been documented to correlate significantly with body fat, morbidity, and mortality (Aronne, 2002).

Commonly agreed upon BMI thresholds have been established to identify patients at higher risk for developing obesity-related diseases. These include Type 2 diabetes, cardiovascular disease, and hypertension (Lyznicki, Young, Riggs, & Davis, 2001). Medical risks rise progressively with increasing levels of body fat beginning with overweight (BMI 25.0 to 29.9), through to obese (BMI 30.0 to 39.9), and followed by extreme obesity (BMI \( \geq 40 \); Aronne, 2002). Deaths attributable to comorbidities associated with obesity have been estimated to be as high as 80% for individuals with a BMI of 30 or higher (Aronne, 2001). Researchers have stated that the diagnostic performance of the BMI measurement is somewhat limited in that it may underestimate or overestimate health risks in particular adults, including individuals over the age of 65, young adults not at full growth, and muscular adults (e.g., Frankenfield, Rowe, Cooney, Smith, & Becker, 2001; Health Canada, 2011; Romero-Corral et al., 2008).

In addition to BMI, waist circumference is another frequently used measure of obesity and has been cited as a practical marker of visceral abdominal fat (Aronne, 2002).
High-risk waist circumferences are generally agreed upon to be 35 inches or greater for females, and 40 inches or greater for males. Research has demonstrated that visceral abdominal fat is associated with higher health risks than peripheral fat. Thus waist circumference, as a practical measure of visceral abdominal fat, aids in the determination of appropriate obesity treatments, as well as identifying estimates of risk in the elderly for example, where BMI alone may underestimate risks due to naturally decreased muscle mass (Janssen, Katzmarzyk, & Ross, 2004).

Considering the increasing rates of individuals who are overweight or obese, there is a common, worldwide agreement among a diverse range of academics, practitioners, researchers, and policy makers that prevention efforts need to be at the forefront of health-promotion activities (O’Dea, 2005). Health Canada (2006) has declared that in order to increase the overall health of the population, it is imperative to achieve and preserve a “healthy weight.” As such, obesity was taken on as a major public health issue. Bocquier et al. (2005) have contended that the challenge to public health regarding the obesity epidemic requires not only modifications of individual behaviours but also important environmental changes. Scientific evidence proliferates the obesity dialogue relating to the “obesity crisis” as well as its causes, consequences, and prevention efforts (Rich & Evans, 2005). Health promotion initiatives are often based on warnings relating to the increasing costs associated with obesity-related health concerns and the savings that would result from successful obesity prevention and management. It has been reported that obesity costs Canada $6.0 billion a year, 4.1% of total health care expenditures (Anis et al., 2010). As such, individuals who are overweight or obese are
often labelled as unwell through mere observation, and viewed as a tremendous burden to society (Goodman, 1995).

**Consequences of Weight-Related Fears**

As a result of the heightened attention paid to health-related risks associated with obesity, well-intentioned medical concerns have unfortunately been translated into a more generalized and normalized anxiety about overweight or obese bodies in general (Burns & Gavey, 2004). Feminist research has highlighted the consequences of this adapted view on larger bodies, including the detriments of a weight-preoccupied society on the wellbeing of individuals who fail to meet what’s been narrowly defined as “acceptable” (Goodman, 1995). Importantly, as Rich and Evans (2005) depict, portrayals of the obesity epidemic not only provide factual information to digest, but also insinuations and assumptions about bodies and health that powerfully influence our understanding of this issue. More specifically, the medicalized view of obesity embodies the supposition that body weight and shape define health. The inherent problem with this assumption is that it denies the reality that weight and health are complex and multifaceted. Importantly, Bugard (2009) declares that weight only accounts for approximately 9% of one’s health. Genetic predisposition is a more influential weight determinant, with environmental variables such eating behaviours and activity levels playing a much lesser part than we are led to believe (Wann, 2009).

The labeling of larger body sizes as unhealthy has come under fire for causing undue fears about overweight or obese bodies. Concerns surrounding the serious implications of being overweight or obese are perpetually fuelled by the repetition of
messages portrayed in both the media and health promotion initiatives (Burns & Gavey, 2004). In line with Burns and Gavey’s (2004) research, Rich and Evans (2005) highlight the implications of public health messages that generate alarm and panic surrounding the nature of obesity and associated consequences to one’s health. Unfortunately, the medical construction of obesity as a major health threat creates an overgeneralization, labelling anyone who is overweight or obese as being unhealthy (Burns & Gavey, 2004). Popular Western culture has embraced these overgeneralizations, embarking on a journey showcasing what has been deemed the ultimate in women’s “health” and “beauty” (Goodman, 1995)

**Popular Western Culture’s Preoccupation With Weight**

The focus on thinness and weight loss as the means to an end in achieving optimal health is widespread in the obesity discourse (Campos, 2004); popular culture reinforces this weight and health dialogue, incorporating another variable related to aesthetic appeal (Goodman, 1995). The message being sold by popular culture to girls and women alike is that in order to be beautiful one must be thin and youthful. Add the more recent conceptualization of health to this equation and now you must not only be thin to be beautiful, but you must also be “fit.” Beauty ideals have been prevalent for hundreds of years, during which time cultural fascinations with weight and the ideal body have transformed tremendously. More than 100 years ago, for example, a full-figured body was the ideal, and considered aesthetically appealing (Goodman, 1995).

Simply glancing at mainstream advertisements and magazine covers, it can be seen that larger women are vastly underrepresented in mass media. When they do appear
they are often portrayed as unglamorous, unlovable, loud, and aggressive characters, where thin women are depicted as glamorous, lovable, cultured, and attractive (Bordo, 1993). Goodman (1995) remarked that larger women receive a special and permanent placement in the “before” pictures of any weight-loss advertisements, fuelling the message associating weight with health.

Cultural ideals of beauty objectify women to a standard to which men are not held (Jutel, 2001). Fraser (2009) declared the potential for tremendous implications associated with these messages as portrayed by popular culture, including both psychological and physical consequences inherent to pursuing an unrealistic and often unattainable ideal. Among the consequences of cultural pressures to be thin are the effects of social disapproval and the stigmatization of larger individuals, which have been deemed acceptable and even justified, based on the assumption that body fat is detrimental to one’s health (Puhl & Brownell, 2006).

**Health as a personal and moral responsibility.** As was previously mentioned, over the last few decades there has been an increasing focus on body weight as an indicator of health, not only in official policy but in cultural practices as well. For instance, Jutel (2001) contended that society’s desire to quantify health arises from the preoccupation to adopt a “model of precise normalcy” (p. 284). The concept of body size being equated to the status of one’s health has resulted in a drastic narrowing of tolerance toward individuals who are overweight or obese (Conrad, 1994). Researchers have suggested that the search for “wellness” has even proliferated moral discourses whereby today’s society constructs a moral world of good, bad, and should regarding health.
activities and particular lifestyle routines (Conrad, 1994). Lupton (1995) argued that the medicalization of obesity, wherein being obese is equated to being unhealthy, fuels current cultural values regarding the preservation of health and evading illness as a personal and moral responsibility.

As Rich and Evans (2005) put forth, this is problematic not only in how it feeds into the discrimination and stigmatization of obesity, but also in its potential to drive some individuals toward disordered relationships with the body and food. Researchers have documented the constant strive some individuals have to be thin, to meet not only cultural aesthetic standards but also supposed health standards (e.g., Battle & Brownell, 1996; Berg, 1999; Burns & Gavey, 2004). Antoniou’s (2009) research highlighted extreme forms of weight-control behaviours in women, motivated by the fear of becoming fat. However, reducing body size may not always be the answer to attaining health (Burgard, 2009). Research has demonstrated that many people who are moderately active but whose bodies are considered overweight are in fact healthier than their thin yet sedentary counterparts (e.g., Burgard, 2009; Gaesser, 2003; Rich & Evans, 2005; Robison, 1997).

**The weight-loss industry.** Alongside the abundance of messages highlighting the risks associated with overweight bodies are copious ways to “fix” weight problems. The diet industry, for example, estimated to be a billion-dollar industry, feeds consumers’ minds with the message that there is a quick fix to addressing obesity, one that falsely promises weight loss as being within a person’s control (Wann, 2009). As Goodman (1995) eloquently stated:
In order to keep the multi-billion-dollar weight-loss industry afloat, purveyors of diet products exploit and manipulate the insecurities of all women, but especially big women, assuring them that happiness is just around the corner if they will use their self-loathing as a springboard to move toward the land of the living. (p. 28)

However, accounts of dieting being harmful to one’s health and wellbeing are often omitted from the widespread diet messaging. Conversely, diet industries permeate women’s minds with unchecked assumptions including the idea that weight is controllable, that being overweight or obese is equivalent to being unhealthy, and that diets are effective modes of treatment (French & Jeffery, 1994). In reality, the extant literature reveals numerous documentations citing the ineffectiveness of dieting, and the harmful effects of dieting on physical health (e.g., long-term damage to the heart and metabolic system) and psychological wellbeing (e.g., body dissatisfaction, body hatred, disordered eating, and eating disorders; French, Jeffery, & Murray, 1999; Wann, 2009).

While popular Western culture has taken hold of these lucrative measures to control weight, the medical community has engaged in their own initiatives for addressing the obesity epidemic.

**Health Promotion Initiatives in the Medical Community**

In response to reported health threats related to obesity, the scientific community has been extensively involved in research targeting appropriate weight-loss initiatives and interventions (e.g., Beaudoin et al., 2001; Raine & Wilson, 2007; Shiffman et al., 2009). Further, general practitioners (GPs) have been identified as being in the ideal position to
address and implement weight-related care (Bocquier et al., 2005; Cherry, Burt, & Woodwell, 2003; Shiffman et al., 2009). A substantial percentage of the population is seen by their GPs on a yearly basis (Campbell, Engel, Timperio, Cooper, & Crawford, 2000). Beaudoin et al. (2001) concluded that long-term regular contact with the public provides GPs with an opportune environment in which to raise the issue of weight with their patients. Concurrently, the 2006 Canadian Clinical Practice Guidelines on the Management and Prevention of Obesity has stated that there is sufficient evidence to recommend physicians to provide lifestyle counselling to their patients during yearly physical examinations (Lau et al., 2007). However, GPs have varied views regarding their abilities, skills, and resources in providing comprehensive weight-related care (Epstein & Ogden, 2005).

**General Practitioners’ Views and Practices Addressing Obesity**

Prior to reviewing GPs’ weight-related views and practices, it is important to recognize the significant time and other practical constraints doctors face within the Canadian medical system (Kirk et al., 2014). Research suggests that GPs communicate a high awareness of obesity as a medically pertinent concern and perceive weight-related care as part of their responsibilities (Kristeller & Hoerr, 1997). However, training, skills, and resources are reported as major contributors to whether or not GPs feel comfortable participating in lifestyle counselling with their patients (Forman-Hoffman et al., 2006). Furthermore, lack of knowledge or use of practice guidelines related to weight-management interventions also appears to be a pertinent issue. Piccinini-Vallis (2011) demonstrated that out of 425 office-based GPs interviewed in Nova Scotia, Canada, only
37.5% of respondents reported being aware of the 2006 Canadian Clinical Practice Guidelines on the Management and Prevention of Obesity in Adults and Children.

Regarding training, researchers have demonstrated that many GPs do not feel adequately equipped to address patients who are overweight or obese (Brown, Thompson, Tod, & Jones, 2006). Bocquier et al. (2005) demonstrated that 80% of GPs acknowledge the necessity of better training regarding the management of their overweight or obese patients. Additionally, Bocquier et al. (2005) were interested in the potential association between a GP’s age and their particular clinical practices. The researchers hypothesized that younger GPs may have better informed practices related to training in obesity management and nutrition than older GPs; however, their findings did not demonstrate any significant association between age and weight-based treatment knowledge. According to Foster et al. (2003), fewer than 50% of GPs felt capable of providing weight-management strategies, and only 14% felt as though they were successful in supporting their patients’ weight-loss activities.

Although there exist strong recommendations enforced by nationwide clinical guidelines to diagnose and manage weight issues in patients (Bocquier et al., 2005), results have demonstrated that under half of GPs are providing such interventions to overweight and obese individuals (Heintze et al., 2010). In a national sample of 1,873 American adults who were classified as obese and who had visited a physician within the past 12 months, fewer than half of the patients (39%) reported being advised to lose weight. Individuals at greater odds of being advised to lose weight were adults between the ages of 40 and 49 who reported fair to poor health as well as chronic illnesses (Ko et al., 2008). Similarly, Kirk, Tytus, Tsuyuki, and Sharma (2012), having examined data
drawn from a general population survey aimed at understanding the experiences of overweight and obese Canadians with weight-management practices, demonstrated that 30% of overweight or obese participants ($n = 320/1062$) reported receiving unsolicited weight-loss advice from their physicians. Weight-loss advice was provided most frequently to middle-aged and older adults, as well as individuals with higher BMIs and comorbidities.

A number of studies concluded that GPs are, in fact, reluctant to address obesity issues during doctor-patient encounters (e.g., Bish et al., 2005; Lang, Tate, Wing, & Sciamanna, 2000; Shiffman et al., 2009; Will, Galuska, Serdula, & Ford, 1999). Particular barriers cited in the research literature included lack of time, training, reimbursement for management efforts, confidence in their skills at delivering weight-loss information, cynicism regarding weight-loss intervention efficacy, as well as fear of generating negative reactions in their patients (Brown et al., 2006; Epling, Morley, & Ploutz-Snyder, 2011; Foster et al., 2003; Frank, 1993; Lyznicki et al., 2001; Shiffman et al., 2009; Wadden & Didie, 2003). In a study conducted by Brown et al. (2006), GPs reported that they lacked the skills necessary in providing effective treatment options while maintaining a positive relationship with their patients. Research has also demonstrated that GPs often do not feel prepared to address behavioural or psychological issues as their background training in traditional medicine focused on the biological underpinnings of diseases versus the science of behaviour (Foster et al., 2003).

Nonetheless some GPs are addressing the topic of weight with their patients (Foster et al., 2003), and questions regarding the ambivalence of GPs in providing weight-management interventions have been posed. In a study conducted by Shiffman et
al. (2009) examining weight-loss interventions provided by physicians, 50% of participants who were obese reported receiving information related to health problems associated with being overweight, as well as advice on achieving weight reduction. Diet and physical activity were the most frequently advocated weight-loss approaches. Similarly, Kirk et al. (2012) showed that of the 383 patients who were overweight or obese and had asked their physicians for weight-loss support, 4% reported receiving no weight-loss advice, 68% obtained advice related to diet, 62% reported receiving exercise advice, 12% were instructed to access support through weight-loss programs and meal replacements/supplements, and 4% were prescribed anti-obesity medication.

In line with these results, research has demonstrated that the two most regularly discussed lifestyle modifications provided in primary care relate to diet control and physical activity (Beaudoin et al., 2001). An Australian study on GPs’ practices and attitudes with respect to obesity management found that many GPs regarded the provision of information about diet and physical activity as being more important than long-term follow-ups (Tan, Zwar, Dennis, & Vagholkar, 2006). In a large national survey of family physicians conducted by Phelan, Nallari, Darroch, and Wing (2009), results indicated that increasing physical activity, reducing fast food consumption, and decreasing portion sizes were the most commonly advocated weight-loss approaches. Moreover, Potter, Vu, and Croughan-Minihane (2001) reported that the most frequently used weight-management interventions provided by family physicians included a discussion of the health risks associated with obesity, exercise recommendations, and dietary advice.

As well intentioned as these weight-related interventions may be, there is a growing body of evidence that highlights the adverse effects of a number of health-
promotion initiatives (Rich & Evans, 2005). As previously mentioned, researchers have illuminated the detrimental messages put forth, relating to the obesity crisis, where weight is equated to health (O’Dea, 2005). Many women have, at times, taken the prescribed directives regarding “controlling one’s weight” to extremes. In the 1970s, when weight messages were first being publicized, there was an exponential rise in disordered eating (O’Dea, 2005). Furthermore, Rich and Evans (2005) posited that health-promotion narratives emphasized language based on the dangers and risks of obesity, with a naivety regarding the ethical implications of such discourse and the influence it may have on individuals and the wider cultural understanding of weight and health.

The inherent problem related to equating weight with health is the emphasis on the need to reduce one’s body size in order to become or remain healthy. Unfortunately, this focus may send the wrong message to individuals who believe that taking measures to become healthy involves extreme practices focused on reducing body weight. Weight-management practices, when taken to such extremes, have been documented as being highly detrimental to health (Rich & Evans, 2005). Accordingly, some of the most well intentioned obesity-prevention initiatives may be more damaging than beneficial to individuals dealing with issues surrounding weight (O’Dea, 2005).

**Intersecting the Obesity and Eating Disorder Literature**

Considering the common themes regarding information provided by GPs on weight-management interventions—namely, a focus on body-size reduction via diet and physical activity—it is important to explore the influence of these instructions within
another domain of health. Until the past decade, clinicians and researchers frequently considered obesity problems and eating disorders as being two distinct issues (Irving & Neumark-Sztainer, 2002). However, Roehrig, Thompson, and Cafri (2008) have more recently highlighted the importance of uniting these two areas of exploration, as research has illuminated potentially shared etiology and risk factors (Battle & Brownell, 1996).

In concordance with this line of reasoning, Haines and Neumark-Sztainer (2006) remarked that weight-related disorders are not so distinct. Many of the frequent characteristics or risk factors of eating disorders, such as body dissatisfaction, low self-esteem, dieting, and personal weight concerns, are also seen in obesity (e.g., Darby, Hay, Mond, Rodgers, & Owen, 2007; Downs, DiNallo, Savage, & Davison, 2007; Irving & Neumark-Sztainer, 2002; Neumark-Sztainer et al., 2007; Urquhart & Mihalynuk, 2011). Cross-sectional research has demonstrated that in the same individual, weight-related disorders can appear concurrently, and people may cross over from one condition to another (Downs et al., 2007). Irving and Neumark-Sztainer (2002) have argued that clinical eating disorders, obesity, and unhealthy weight-loss measures are all part of a spectrum of food- and weight-related problems that are, as they describe it, “symptoms of a toxic cultural context that inhibits the development of healthy patterns of eating and physical activity and discourages a healthy respect for diverse body weights and shapes” (p. 300).

In popular media, disordered eating patterns are often associated with underweight individuals. However, research has demonstrated that these patterns of behaviour and thinking are frequently seen in people who are overweight as well (Darby et al., 2007). Numerous studies have shown that females who are overweight reported
greater use of unhealthy weight-control behaviours than individuals who are not overweight (Desai, Miller, Staples, & Bravender, 2008; Gadalla, 2008; Neumark-Sztainer, Perry, Hannan, Irving, & Story, 2002; Urquhart & Mihalynuk, 2011). For example, Neumark-Sztainer et al. (2002) found that the use of unhealthy weight-loss methods, including diet pills, self-induced vomiting, laxatives, and diuretics, were more likely to occur in individuals who were obese than in those who were not. Urquhart and Mihalynuk (2011) affirmed that in overweight individuals, disordered eating is common and has been associated with the progression of weight gain and the development of eating disorders over time (Gadalla, 2008). Furthermore, it has been reported that about 10% to 30% of individuals who are overweight or obese meet the criteria for binge-eating disorder (Grilo, 2002). Irving and Neumark-Sztainer (2002) found similar results acknowledging that approximately 30% of individuals frequenting weight-loss clinics could be diagnosed with binge-eating disorder.

**Pro-Dieting and Anti-Dieting Messages**

Reflecting on the eating disorder and obesity literature as a whole, similar to what Irving and Neumark-Sztainer (2002) postulated, the two fields have a common goal focused on increasing health-related behaviours and decreasing dysfunctional eating patterns. However, the fields are also divergent in important ways. The most apparent difference is what Roehrig et al. (2008) describe as the “pro-dieting” and “anti-dieting” messages inherent within the treatment of obesity and eating disorders respectively.

Generally speaking, the pro-dieting message encouraged by many obesity prevention programs focuses primarily on diet and restricting the amount of calories one
consumes, as well as promoting increased physical activity in order to decrease weight. Accompanying these endorsements is a lack of focus on the roles played by genetics and environmental factors—both contributing variables in individuals who are overweight and obese. Alternatively, the anti-dieting message, supported by the eating disorder field, urges individuals against dieting by promoting eating and exercising in moderation. Further, the anti-dieting message highlights the role of genetics in body weight, as well as the encouragement of compassion toward all body shapes and sizes (Roehrig et al., 2008).

**Consequences of pro-dieting initiatives.** Although dieting has been promoted by the obesity field as a way to address weight concerns and associated health risks (Lyznicki et al., 2001), many studies have reported the potential negative consequences of dieting behaviours (e.g., Berg, 1999; Burns & Gavey, 2004; McFarlane, Polivy, & McCabe, 1999). For example, “weight cycling”—where people lose and regain a large amount of weight—is often associated with dieting and has prompted cardiovascular-related concerns (Ernsberger & Koletsky, 1999). Psychological consequences have also been tied to dieting including the association between diet behaviours and increased levels of depression, anxiety, and social isolation (French & Jeffery, 1994; Griffiths et al., 2000; Powell & Hendricks, 1999; Stice, 2002).

Furthermore, longitudinal studies have shown that dieting, in part, can predict future disordered eating patterns and obesity (Patton, Selzer, Coffey, Carlin, & Wolfe, 1999; Stice, Cameron, Killen, Hayward, & Taylor, 1999). One study by Roehrig et al. (2008) investigated the immediate and short-term effects of dieting-related
psychoeducation messages on weight-control intentions and behaviours as well as psychological functioning. The researchers found that prodieting messages, at post-test, stimulated higher levels of established risk factors for eating disorders, including perceived pressure to be thin. Likewise, reviews of correlational and prospective findings have also linked dieting and eating disorder symptomatology in some at-risk populations, remarking that dieting can be significantly influential toward the development of an eating disorder (Hsu, 1996).

Another distinction in the eating disorder and obesity fields relates to body image satisfaction/dissatisfaction. In many programs focused on addressing weight concerns, there is an assumption that it is appropriate to be dissatisfied with one’s body size (Urquhart & Mihalynuk, 2011). Irving and Neumark-Sztainer (2002) highlighted obesity research where body and weight dissatisfaction were outlined as an appropriate and necessary motivational prerequisite in weight-loss programs. In the eating disorder literature, body dissatisfaction is a strong and consistent risk factor for the later development of disordered eating and eating disorder symptomatology (Cash & Deagle 1997; Grogan, Williams, & Conner, 1996; Schwartz & Brownell, 2004). Body dissatisfaction has not only been cited as a risk factor for disordered eating but also for negative psychological consequences such as depression, anxiety, and poor self-esteem (e.g., Cash & Fleming 2002; Johnson & Wardle, 2005; Neumark-Sztainer, Paxton, Hannan, Haines, & Story, 2006). Accordingly, body self-acceptance, at any weight and shape, with the aim of encouraging increased body satisfaction, is a key concept in the prevention and treatment of eating disorders (Irving & Neumark-Sztainer, 2002).

More recently, the issue has been brought forth as to whether the emphasis on
weight reduction in order to attain health is the most appropriate measure to address weight issues in overweight or obese individuals. Questions have been raised regarding the conceptualization that individuals have to be thin in order to be healthy, as well as the idea that weight-related health issues are improved via weight loss (Robison, 1997). Burgard (2009) acknowledged the lack of empirical evidence supporting substantial weight loss in the improvement of long-term health, beyond modest weight loss of 5% to 10% of body weight. Interestingly, a good deal of research has been accumulated providing evidence that some weight-related health concerns, such as elevated cholesterol and triglyceride levels, high blood pressure, and glucose intolerance, can be addressed and improved independently of weight reduction (Gaesser, 2003). This emerging literature proposes that, for those individuals struggling with weight, the emphasis on weight loss to achieve health may actually be counterproductive and even harmful (Rich & Evans, 2005). Subsequently, new alternatives to health and fitness have transpired with increased focus on establishing a healthy lifestyle while placing less emphasis on body weight and size (Gaesser, 2013). An example of this newer approach to health is seen in the promotion of the Health at Every Size (HAES) initiative (Robison, Putnam, & McKibbin, 2007).

**Health at every size.** In accordance with this alternative approach to health and wellness, Health at Every Size (HAES) has evolved as an anti-dieting movement that encourages and supports individuals in living a meaningful and gratifying lifestyle as a means to promote good health (Robison, 2005). The theorists behind HAES have critiqued the traditional biomedical emphasis on weight loss as a means to improve
health, suggesting that this model, based on emerging research, should be seriously questioned (Robison et al., 2007). Alternately, HAES shifts the emphasis from a weight-focused approach to a health-focused approach (Penney & Kirk, 2015). Specifically, the HAES paradigm is premised on the following beliefs:

(1) Thin is not intrinsically healthy and beautiful, nor is fat intrinsically unhealthy and unappealing; (2) Individuals naturally have different body shapes and sizes and different preferences for food and physical activity; and (3) Dieting usually leads to weight gain, decreased self-esteem, and increased risk for disordered eating. Health and happiness involve a dynamic interaction among mental, social, spiritual, and physical considerations. (Robison et al, 2007, p. 186)

The underlying assumption of HAES is that one’s health cannot be determined by measurements such as BMI, body-fat percentage, or the numbers on a scale. Rather, healthy weight is defined as the weight in which individuals settle into when they are eating in relation to internal hunger cues, participating in enjoyable and maintainable levels of physical activity, and moving toward meaningful and fulfilling lifestyles (Robison, 2005). This approach focuses on producing health benefits autonomous from weight loss. The overarching goal of HAES is helping health professionals and individuals alike to focus on “health improvement” versus weight-loss. This approach has been deemed to have more desirable effects on health as it encompasses the physical, psychological, social, and spiritual aspects of health, not simply the physical dimensions (Gagnon-Girouard et al., 2010).
The HAES paradigm and related movements facilitate a more compassionate view of body shape and size, and support anti-stigma advocacies in the ways in which weight interventions are delivered (Penney & Kirk, 2015). As Bugard (2009) contended, this has true value not only for individuals who are overweight or obese, but also for public health as HAES paves an accessible route that is more practical for all. However, Penney and Kirk (2015) have pointed out the implications of moving forward with an individual-focused approach to obesity management and the lack of consideration for the larger economic, physical, and sociocultural obstacles involved in weight and weight management. Though further empirical support is required before HAES can be confidently promoted, the movement continues to provide promise and hope for a novel outlook on how to approach the issue of obesity treatment in public health (Penney & Kirk, 2015).

There is ample evidence indicating that the prevailing behavioural weight-loss prescriptions are not working and often result in discrimination and stigma toward patients who are overweight or obese (e.g., Brown et al., 2006; Heintze et al., 2010; Malterud & Ulriksen, 2011; Mold & Forbes, 2013; Robison et al., 2007). As previously mentioned, findings have indicated that weight-management interventions provided by many GPs are specifically what the eating disorder literature prescribes against (Jutel, 2001). Furthermore, important psychosocial stressors are void in the current weight-loss prescriptions that often play a role in one’s weight status (Dube, LeBel, & Lu, 2005; Macht & Simons, 2000; Thomas, Hyde, Karunaratne, Herbert, & Komesaroff, 2008).

As elucidated by Burns and Gavey (2004), considering the culture in which health messages are delivered, it is not unreasonable to speculate that intersections between
weight-loss advice for the attainment of health, and gendered constructions encompassing the embodied deviance of “fatness,” might have implications for how women feel about their bodies and their body-management practices. Frontline professionals need to be aware of the potentially adverse effects their well-intentioned initiatives may have on their patients’ health and wellbeing (Rich & Evans, 2005). Odgen et al. (2001) contended that differences in attitudinal beliefs about obesity causation between patients and health care providers may cause tensions that influence the successfulness of obesity treatment and the quality of care received.

**Views on Obesity Causation**

Heintze et al. (2010) argued that the outcome of obesity management by general practitioners remains poor. One of the potential hypotheses as to why interventions may fail is based on differing views of obesity causation. Specifically, there has been growing evidence that many GPs and patients have different attitudinal and perceptual models of weight causation, thus creating potential rifts in the doctor-patient relationship (Ogden et al., 2001). Causation of obesity appears to largely interact with treatment approaches and attitudes between patients and physicians (Ogden, 1994). Some authors have cited a victim-blaming approach in the medical community wherein overweight individuals are blamed and shamed for their overweight bodies (Brownell, 1991; Odgen et al., 2001).

In a study conducted by Bocquier et al. (2005), results demonstrated that GPs’ views of overweight and obese patients were based on a model that placed the onus on the individual for being overweight or obese (i.e., obesity causation based on behavioural factors such as physical activity or food regimens). It was noted that this view conflicted
with patients’ perceptions regarding being overweight and obese, in which participants attributed more importance to risk factors over which they had little or no control (e.g., obesity causation based on genetic factors, unemployment, stress, and other environmental and social factors). In a study by Foster et al. (2003) examining 620 primary care physicians’ attitudes about obesity and its treatment, results demonstrated that doctors rated inactivity, overeating, and a high-fat diet as significantly more important than any other possible cause of obesity, including genetic factors.

These results are in line with a similar study conducted in the United Kingdom reporting that 255 GPs perceived physical inactivity as the principal cause of obesity (Harvey & Hill, 2001). Furthermore, in a study that examined 89 GPs’ models of obesity and assumptions about patient behaviours, GPs reported that obesity was attributable to overeating as opposed to more internal variables outside the patient’s control, such as gland/hormone problems, slow metabolism, stress, and low income (Ogden et al., 2001). As the researchers concluded, this model of obesity echoes a victim-blaming attitude in which patients are thought of as both the cause of and solution to their problems. In general, the behavioural causes of obesity are overemphasized considering that heritability of obesity has been estimated to be as high as 50% to 70% in modern developed populations (Segal & Allison, 2002). It has been suggested that beliefs about the etiology of obesity influence GPs opinions regarding personal characteristics of patients who are obese. Specifically, GPs’ views on obesity causation, at times, have been associated with negative stereotypes of their overweight or obese patients, which can have detrimental effects on the quality of care received, not to mention their patients’ sense of self (Foster et al., 2003). The ideation of placing individuals under full control of
their weight stems from a larger societal problem related to obesity stigmatization also known as “weightism” (Puhl & Heuer, 2009).

The Obesity Stigma

Link and Phelan (2001) provided a description of stigma that acknowledges the interrelated components encompassing stigmatization. In their view, the definition of stigma should be applied in situations in which “elements of labelling, stereotyping, separation, status loss, and discrimination co-occur in a power situation that allows the components of stigma to unfold” (p. 367).

Obesity stigmatization permeates Western society. In fact, obesity is highlighted as one of the few “acceptable” types of discrimination maintained to this day (Klaczyński, Daniel, & Keller, 2009). Watts and Cranney (2009) have contended that oppressive fat attitudes are often excused and even rationalized. This prejudice is justified in a number of ways including the belief that every person should have the capability of controlling their weight through diet and physical activity, that weight is the personal responsibility of the individual, and that shaming individuals who are overweight or obese is an appropriate and successful motivator in persuading people to adopt a healthier lifestyle (Puhl & Heuer, 2010).

In recent years, there has been an increased recognition of the pervasiveness of weight stigmas, as well as the detrimental physical and psychological effects on individuals who are overweight or obese (Puhl & Heuer, 2009). Because of the highly visible nature of weight, individuals who are larger in size are subject to multiple forms of prejudice, negative attitudes, and discrimination (Puhl & Heuer, 2009). This weightism
is associated with inequalities in employment settings (Roehling, 1999), education (O’Brien, Hunter, & Banks, 2007), interpersonal relationships (Puhl & Heuer, 2009), families (Puhl & Brownell, 2006), and many other environments (Puhl & Brownell, 2001). With regards to prejudiced attitudes and views, Bordo (1993) described common labels associated with overweight individuals including, lazy, weak, unsuccessful, and deviant. Puhl and Brownell (2001) reported several other prominent labels such as unmotivated, unintelligent, less competent, noncompliant, and sloppy. As depicted by Bordo, in a “fat-hating” society, fat is seen as hazardous, unhealthy, and defective.

Discrimination, distinct from prejudice and negative beliefs, and referring to unequal treatment of individuals based on their membership in a particular group, has also proven to be widespread in today’s society (Puhl, Andreyeva, & Brownell, 2008). In a sample of 3,437 Americans, individuals who were obese reported significantly more interactions of a discriminatory nature in a number of different settings (e.g., work-related discrimination, health-related discrimination, and frequent daily discrimination) when compared to individuals who were not overweight or obese (Carr & Friedman, 2005).

Puhl et al. (2008) further explored weight discrimination, demonstrating similar results. Specifically, higher obesity levels for all adults in their sample significantly increased the risk of discrimination. Individuals who are obese, they discovered, are six-times more likely to report weight/height discrimination than individuals who are not obese. Attribution theory from social psychology has been used to offer an understanding of weight prejudice, stigma, and discrimination (Musher-Eizenman, Holub, Miller, Goldstein, & Edwards-Leeper, 2004). For instance, Puhl and Brownell (2001) have
suggested that people discriminate against larger individuals based on the belief that weight is controllable. Specifically, attributing controllability to one’s weight fuels weight-based stigma, as people are perceived to be responsible for their weights, and therefore blameworthy should they not adhere to acceptable weight standards.

**Gender, Ethnicity, SES, and Weightism**

Research literature exploring gender and weightism has demonstrated significant differences between men and women (Puhl et al., 2008). Feminist activists were among the first to bring forth how issues surrounding women’s weight and health were targeted more fiercely than those same issues with men (Robison et al., 2007). Puhl et al. (2008) found a prominent gender difference associated with BMI levels and risk for discrimination, demonstrating that women are twice as likely to report weight discrimination than men. Additionally, gender differences were seen when examining BMI levels. In particular, women reported experiencing increasingly notable weight/height discrimination at a BMI level of 27, whereas males did not report a significant increase in discrimination until reaching a BMI of 35 or higher. This is comparable to other studies demonstrating significant gender differences in weight-biased attitudes and discrimination (e.g., Falkner et al., 1999; Hebl & Turchin, 2005).

Furthermore, researchers have demonstrated that labels attached to obesity are far worse and more frequent for women who are obese. In concordance with the medicalization of obesity, Burns and Gavey (2004) highlighted how to be a woman who is overweight or obese means not only being viewed as an “aesthetic failure,” but also as someone who is “lazy” and “unwell.” Bordo (1993) noted how femininity was connected
with exerting control over desire and appetite, arguing that failing to do so stripped women of their feminine appeal. Researchers have demonstrated that the influences of Western ideals of female thinness exacerbate an exceptionally harsh burden on women to adhere to unrealistic weight standards (Puhl et al., 2008). Western culture fuels images of thin women as living fulfilled, active, and controlled lives while depicting larger women’s lives as being void of these qualities (Puhl et al., 2008). Goodman (1995) discussed how women who are overweight or obese must overcome extreme barriers including those of equal rights and privileges that women as a whole, fought for during the early days of feminism. “Weight is really a framework for issues like power, entitlement, control, conformity, and all the ways in which society grants or withholds approval, love, sex, social status, and opportunities” (Goodman, 1995, p. 14).

Differences in weight biases also appear among ethnic groups. In a recent study completed by Puhl et al. (2008), results showed that minority groups, particularly African-American women (23.9%) and men (12.7%), experience more prominent weight discrimination compared to Caucasian women and men. Puhl et al. (2008) have cautioned that further work is needed to clarify the presence and nature of differences between ethnic backgrounds and weightism. Interestingly, Hebl and Heatherton (1998), who examined African Americans’ attitudes and beliefs about obesity, found that participants held generally favourable attitudes regarding overweight or obese African Americans. The researchers noted that it is unclear as to whether this greater level of body weight/size acceptance could provide insight into resiliency factors against the overall weightism prevalent in today’s Western society.
Further marginalization occurs in people who are overweight or obese and of low socioeconomic status (SES). The connection between obesity and SES is also well documented in the research literature, with decreasing SES levels associated with an increasing prevalence of obesity (Sobal & Stunkard, 1989). Goodman (1995) documented that the prevalence of individuals who are overweight and obese is greater among those who are economically and socially disadvantaged. Furthermore, in the context of low SES, overweight adolescents are at even higher risk of experiencing social marginalization compared to “normal-weight” adolescents (O’Dea, 2005). As demonstrated by the results above, individuals who are overweight or obese are subject to multiple forms of prejudice and discrimination. Unfortunately, the medical community is not free from negative attitudes, biases, and reactions toward individuals who are overweight or obese (Foster et al., 2003).

**Medical Community and Weightism**

The power dynamic evident within the doctor-patient relationship creates an environment that has the potential to be very stigmatizing (Mold & Forbes, 2013). Well documented in the research literature is evidence reporting prejudice and discrimination in health care environments, including stereotypical attitudes conveyed by a number of different groups involved in the health care profession. Studies completed across Canada, the USA, and the UK exploring health care professionals’ views and experiences with obese patients suggest that, in general, many hold implicit negative attitudes and beliefs relating to individuals who are obese (Puhl & Heuer, 2009).
In the study from Bocquier et al. (2005), approximately 30% of GPs conceptualized individuals who were overweight or obese as “lazier” and “more self-indulgent” than their non-overweight/obese counterparts. Olson et al. (1994) found that medical students’ perceptions of obese patients included labels such as “weak-willed,” “ugly,” and “awkward.” Furthermore, perceptions toward their obese patients—more frequently than their non-obese patients—encompassed negative evaluations in a number of areas including compliance with treatment recommendations, health status, and diet quality. Even after patients provided evidence indicating healthy lifestyles, some health care professionals still assumed that their obese patients had a more negative approach to diet and health (Puhl, Wharton, & Heuer, 2009). In another study conducted by Foster et al. (2003) examining the attitudes of 620 primary care physicians regarding obesity and its treatment, results indicated that over 50% of participants perceived patients who were obese as “awkward, unattractive, ugly, and noncompliant” (p. 1168). This sort of weight stigma does not go unnoticed by patients.

A number of studies have been completed that illuminate the experiences of patients in dealing with weight-based stigma and, consequently, disruptions in care (e.g., Mold & Forbes, 2013; Goodman, 1995; Puhl & Heuer, 2009; Rogge, Greenwald, & Golden, 2004). Rogge et al. (2004) documented that patients who are obese often experienced stigmatized behaviours, causing feelings of humiliation, shame, and powerlessness. Goodman (1995) talked about how stigma is expressed by doctors through unsolicited diet and exercise prescriptions, which resulted in patients feeling schooled, threatened, misdiagnosed, and poorly treated due to their size. Fikkan and Rothblum (2012), in their study examining weight bias in health care, showed that weight
bias in the medical community substantiates a tremendous obstacle for women receiving care. They demonstrated that physicians might not thoroughly examine patients who are obese, posing threats to women’s health in the process. Also hazardous to women’s health is the avoidance of important medical appointments due to past experiences of stigma and discrimination within the medical community.

**Health care delivery and utilization.** Negative attitudes and weight-based stigma toward individuals who are overweight or obese have been shown to influence physicians’ outlooks on treating obesity (Foster et al., 2003). In turn, these stigmatizing views interact with the doctor-patient relationship, influencing utilization of medical care (Brown et al., 2006). A number of studies have demonstrated that obesity has a powerful social effect, not only on how individuals regard themselves, but also on how they access and interact with health care providers (Adams, Smith, Wilbur, & Grady, 1993; Fontaine, Faith, Allison, & Cheskin, 1998; Olson et al., 1994).

There is a growing body of research indicating that overweight or obese women often delay or avoid health care services if they have had negative health care experiences in the past (Merrill & Grassley, 2008). Mold and Forbes’ (2013) results, drawn from a recent literature review, demonstrated that interactions in the health care realm were in fact influenced by one’s weight. More specifically, women who are overweight or obese attend preventative health screening examinations (e.g., gynecologic examinations, pap tests, mammograms) significantly less frequently than women who are not overweight or obese (Fontaine et al., 1998). In their study, Olson et al. (1994) illustrated that women who had greater BMIs reported delaying medical care due to embarrassment about their
body size, or because they feared being reprimanded and lectured about their weight.

Congruently, Amy, Aalborg, Lyons, and Keranen (2006), who examined barriers to
gynecological cancer screening, also reported that women who have been repeatedly
reprimanded about their weight often delay important medical appointments, and in turn,
preventable health risks increase.

Brownell, Puhl, Schwartz, and Rudd (2005) provide a conceptualization of the
cycle relating to obesity and bias in health care. Weightism on the part of health care
professionals can lead to negative experiences and responses in patients, which
subsequently may generate further avoidance of services. As such, poor self-care is
exacerbated by health care avoidance, which can lead to negative consequences on one’s
health. Moreover, Rich and Evans (2005) showed how weight biases on the part of the
physician can severely disrupt the doctor-patient relationship and impact the quality of
care received by patients.

It should be noted that patients do not always report weight biases and negative
interactions with GPs. In fact, many patients disclose very positive views regarding the
treatment they received from their physicians for general care. A lack of resources rather
than negative stereotyping or discrimination on the part of the GP was perceived as
having contributed to services not in tune with the needs of many patients (Brown et al.,
2006). Nonetheless, within the realm of weight-management interventions and the
cultural milieu in which these messages are delivered, there is considerable emotion
generated by the topic of weight. Accordingly, it has been suggested that GPs, as well as
other health care professionals, provide information pertaining to issues of weight
management in an encouraging and supportive way (Brown et al., 2006).
Individuals working in primary care are encouraged to be aware of their attitudes and potential biases toward obese individuals, as interpersonal communication and exchanges are the primary means of transmitting important information (Drury, Aramburu, & Louis, 2002; Ong, de Haes, Hoos, & Lammes, 1995). As contended by Munch (2000), the doctor-patient relationship is one of the most complex among interpersonal relationships in that it involves exchanges between individuals of non-equal positions, is often non-voluntary, bears issues of vital importance, and is therefore emotionally laden. As Mold and Forbes (2013) declared, “obesity management is evidently affected by the extent to which the patient feels valued and supported within the medical system and how health professionals respond to the individual needs of the obese patient” (p. 2).

**Review of Patients’ Experiences Receiving Weight-Related Care**

Most of the research on women’s experiences with weight-based interventions in medical care has predominantly been conducted in the USA, the UK, and Australia, with only a few such studies conducted in Canada (Mold & Forbes, 2013). Together, results have demonstrated a common theme regarding weight-related interventions posing challenges for both GPs and patients alike (e.g., Brown et al., 2006; Epstein & Ogden, 2005; Foster et al., 2003; Harvey & Hill, 2001; Tan et al., 2006). The literature exploring women’s experiences receiving weight-related interventions has demonstrated less than satisfactory interactions with health care professionals when compared to medical attention received for other areas of health (e.g., Betfort et al., 2006; Heintze et al., 2011; Malterud & Ulriksen, 2011; Wadden et al., 2000). A closer examination of the
quantitative and qualitative studies highlighting women’s experiences with weight-related interventions provides a better understanding of our current knowledge, as well as areas presenting sufficient need for further inquiry.

**Quantitative Research**

Quantitative research investigating the experiences of women and weight in health care settings has illuminated a number of different issues including: the frequency at which weight-management issues are being broached with patients (Kirk et al., 2012; Shiffman et al., 2009); types of weight-management interventions provided by doctors (Kirk et al., 2012; Wadden et al., 2000); patients’ views on the role of health care professionals in managing obesity (Potter et al., 2001); weight and health care utilization (Adams et al, 1993; Foutaine et al., 1998; Olson et al., 1994); the prevalence of weight-related stigmatization in health care (Puhl et al., 2008); and patients’ satisfaction levels with weight-based care (Olson et al., 1994).

In general, the frequency at which overweight and obese patients report being recipients of weight-loss interventions from health care professionals is usually between 30% and 50% (Kirk et al., 2012; Shiffman et al., 2009). Results have demonstrated that the two most commonly prescribed weight-loss practices are dietary and physical activity advice. However, participants did not feel that their physicians offered much guidance regarding weight-loss practices (Wadden et al., 2000). With regards to what patients would like from their physicians in terms of advice on weight control, studies have demonstrated that patients desire realistic weight-loss goals, as well as specific and practical weight-loss recommendations (Potter et al., 2001).
Importantly, a large number of patients felt that their GP could play an intricate role in supporting individuals in weight-management initiatives (Huang et al., 2004; Loureiro & Nayga, 2006; Walseth, Abildsnes, & Schei, 2011), though they regarded time as an issue in receiving appropriate weight-loss interventions and care (Tan et al., 2006; Potter et al., 2001). In a study conducted by Wadden et al. (2000), a survey of patients’ satisfaction with health care services revealed that while patients were satisfied with their physicians’ care and attention to more general health issues, they were far less satisfied when it came to addressing issues of weight. These findings were more pronounced among women (Wadden et al., 2000).

Closely tied to satisfaction with care, a number of studies reported that patients often reported delaying medical visits due to negative interactions with health care professionals regarding weight, as well as feelings of embarrassment and fear of being reprimanded for their current weight statuses (Adams et al., 1993; Foutaine et al., 1998; Olson et al., 1994). Negative interactions such as these have been associated with reports related to weight-based stigma and stereotypical labels held by a number of health care providers including laziness, overeating, and low intelligence (Puhl et al., 2008). Researchers have demonstrated that damaging experiences with health care professionals can increase treatment avoidance in seeking future medical care (Amy et al., 2006; Olson et al., 1994).

The use of quantitative methodology provides a practical tool in examining weight-management practices in primary care, as well as highlighting the need to make necessary changes in how weight is handled in the health care system. However, in a field of research that encompasses stigma and discrimination (Puhl & Heuer, 2010),
quantitative data cannot capture the complex and multifaceted experiences of participants. Accordingly, qualitative research provides a richer depiction of the experiences, beliefs, and values of individuals involved in weight-based interactions with health care professionals (Charmaz, 2006).

**Qualitative Research**

In the existing literature, qualitative research has illuminated many underlying processes within doctor-patient interactions regarding weight, as well as a wide range of issues that have significant implications for practices within weight-related care. In general, findings from qualitative research have demonstrated a number of challenges faced by patients who are overweight or obese in today’s medical system.

In their qualitative study, Merrill and Grassley (2008) highlighted overweight and obese women’s experiences with weight and health care services. The researchers interviewed eight Caucasian women and used a phenomenological approach to analyze the data. Results displayed four major themes: Struggling to Fit in, related to physical difficulties within health care environments including requiring different gowns, blood pressure cuffs, scales, chairs, and other equipment due to their size; Refusing to Give up, revealed women’s desire and motivation to be in control of their weight and achieve a more “normal” size; Being Dismissed, elucidated women’s feelings of being demeaned, belittled, and misunderstood by health care providers; and Feeling not Quite Human, related to experiences involving weight stigmatization and feelings associated with being different from others. Many of these participants dreaded returning to their health care providers for fear of further stigmatization.
The experience of weight-based stigma was not an uncommon theme in the existing qualitative research literature. For example, Thomas et al. (2008) and Rogge et al. (2004), explored the lived experiences of people with obesity by interviewing 76 and 13 individuals, respectively. In both studies, community samples of adults who were obese based on a BMI ≥ 30 were used. The researchers found that almost all of the participants had experienced stigma and discrimination by a number of perpetrators including health care providers. Thomas et al. (2008) demonstrated that many participants experienced humiliating and derogatory comments from their health care professionals. Findings in both studies demonstrated the impact of stigma and discrimination including feelings of shame, blame, and defectiveness.

In another qualitative study conducted by Ward, Gray, and Paranjape (2009), a number of physicians’ behaviours, both negative and positive, were illuminated. Forty-three African-American men and women, all of whom were considered obese as indicated by a BMI ≥ 30, were recruited and joined eight focus groups. In their study, Ward et al. (2009) aimed to highlight patients’ perceptions on physicians’ behaviours regarding the weight-loss process, as well as beliefs on the role physicians should play in obesity treatment. Results indicated that participants disliked the use of the word “obese,” preferring more neutral terms such as “weight” or “excess weight.” Ward et al. (2009) also highlighted the importance of manner, timing, and tone in which physicians communicated issues of weight to their patients, illuminating the powerful influences these factors can have on how messages are perceived. With regards to what patients would like in terms of weight-loss advice, results indicated the desire for less ambiguous and more personalized information regarding weight-loss strategies.
Brown et al., (2006) demonstrated similar findings in their study investigating the weight-based experiences of obese patients within primary care. The researchers conducted semi-structured interviews involving 28 patients who were recruited from five general practices in the UK. All participants had a BMI $\geq 30$. Results indicated that primary care services lacked the appropriate resources to effectively address their weight. Furthermore, participants felt that information was delivered in a rushed, ambiguous, and/or insensitive manner. In line with findings by Thomas et al. (2008) and Rogge et al. (2004), patients were cognizant of obesity stigmatizations that not only affected access to, and satisfaction with, health care services, but also fuelled feelings of powerlessness and humiliation, affecting how patients felt about themselves and their bodies.

While the qualitative literature illuminated overweight and obese individuals’ experiences with weight-related care in the medical community, further investigation is required to delineate a more detailed and comprehensive understanding within this domain of research. Conducting an inquiry from a critical feminist perspective can help shed particular light on the intersection between experiences of weight-related care and the social context within which women live. A critical feminist lens may also help examine experiences within the doctor-patient relationship where an inequity of power inevitably exists, and vulnerability pertaining to issues of weight and shape is commonly present (Puhl et al., 2008). Furthermore, all studies to date have focused on overweight or obese individuals, which limits practical implications for doctors in providing not only obesity-management information, but also weight-management directives for individuals who present with a diversity of weights. Lastly, the ethnic demographic in qualitative research has primarily focused on a Caucasian population (with the exception of Ward et
al., 2009) and has been carried out in locations with differing medical care systems than that which is present in Canada. Research on Canadians’ weight-based experiences within the Canadian health care system is limited.

**Rationale for the Present Inquiry**

As the literature review exemplified, GPs have been united to implement weight-related interventions with their patients in response to the obesity epidemic (Health Canada, 2005). However, GPs report feeling undertrained in this particular area of care (Bocquier et al., 2005) and outcomes of obesity management remain poor (Heintze, 2010). With GPs exhibiting ambivalence about their abilities, skills, and resources in providing weight-based care, coupled with a cultural milieu that stigmatizes obesity and idealizes thinness (Puhl & Heuer, 2009), the provision of weight-based care faces numerous challenges for both doctors and patients alike.

Many health care professionals do not have the understanding or awareness of how weight-related messages are received by their patients (Merrill & Grassley, 2008), especially female patients who deal with weight scrutiny on an ongoing basis (Goodman, 1995). As previously mentioned, Western ideals for female thinness exacerbate an exceptionally harsh burden for women (Puhl & Heuer, 2009), who face far greater weight-related stigma and discrimination than males (Robison et al., 2007). Undoubtedly, lived contexts, including experiences of weight prejudices, interact with the lens through which women perceive weight-management interventions. Unfortunately, this area of research is lacking. In order to acquire insight into the dynamics within weight-based exchanges, it is imperative to gain a comprehensive understanding of the context within
which patients live their lives, and how this shapes their experiences of weight-related care (Thomas et al., 2008).

The present study has aimed to portray the complexities of weight-related exchanges in doctor-patient interactions, and the ways in which women’s ongoing lived experiences with body size and weight shape their experiences and reactions to doctors’ weight-based practices. Aston, Price, Kirk, and Penney (2012) acknowledge the use of a feminist theoretical lens as an innovative and favourable approach in capturing the complexities within issues of weight in the health care system. Similarly, the present study has employed a critical feminist perspective as its guiding theoretical framework in exploring the ways in which Canadian women experience and make meaning of weight-related interventions provided by their doctors. This perspective enhances the exploration of the ways in which weight-related experiences intersect with societal influences of privilege, power, gender, ethnicity, and social class.

The current study also aimed to address the scarcity pertaining to diversity in the extant literature, as well as to provide further information regarding weight-management information within the specific context of Canadian health care. Specifically, there is a dearth of research exhibiting participant diversity, including body weight and shape, ethnocultural backgrounds, SES, educational levels, and sexual orientation (Mold & Forbes, 2013). The majority of research completed thus far lacks the ethnic diversity that Canadian culture encompasses, as well as applicability to the unique context of the Canadian health care system. Importantly, one sixth of individuals living in Canada are foreign-born, creating a culturally diverse population. Furthermore, Canada’s universal public health insurance system entitles residents of Canada to receive free medical care
for almost all procedures (Davis, 1999), a systemic variable that is different from the USA health care system. Thus, it is essential to explore and understand specifically the experiences of Canadian women receiving weight-management information from their doctors. Constructing insight and knowledge into patients’ experiences and perceptions of weight-based dialogues can help inform and guide GPs in understanding and navigating the complexities of providing sensitive, patient-centred care in Canada. The present investigation, therefore, had the following research questions. First, overall, what are the experiences of women who have received weight-related information from their general practitioners? Second, what would women highlight as positive or negative processes in the doctor-patient interaction when receiving input regarding weight? Third, what suggestions would the women have for doctors who discuss weight-based issues with patients?
CHAPTER TWO

METHODOLOGY

Overview

The purpose of the present study was to gain a detailed understanding of women’s experiences receiving weight-related information or advice from their GPs. Guided by a critical feminist perspective, this study explored the diverse sociocultural factors that interacted with women’s comprehension and perceptions of conversations regarding weight. As previously mentioned, there is a lack of qualitative research pertaining to doctor-patient weight-related interactions in relation to Canadian culture and the medical system. The current study used a qualitative research approach that included in-depth, semi-structured interviews designed to gather narrative data from the 18 women interviewed for the study. Specifically, the study utilized Charmaz’s (2000; 2003; 2005; 2006) constructivist grounded theory approach to gather and analyze the data. Chapter 2 outlines the subjectivity of the researcher, the rationale for the use of a qualitative constructivist grounded theory approach, as well as a detailed description of the participants, procedure, data collection and analysis.

Subjectivity of the Researcher

Highlighting the subjectivity and social location of the researcher in relation to the research project is an important aspect of both feminist-informed research and constructivist approaches to grounded theory (Allen, 2011). It also enhances the trustworthiness and rigor of the study (Morrow, 2007). To this end, it is important for the
researcher to convey any biases, assumptions, or ambitions that inevitably become part of the research study.

The use of a critical feminist perspective is something that I maintain both in my work and in my personal life, and has therefore been the lens through which I have viewed this research project. From this perspective, experiences at the individual level, including the construction of self, are inherently shaped by higher-level societal institutions, widely accepted norms, and structures of power and privilege in relation to one’s social location, gender, race, ethnicity, sexuality, and social status (Qin, 2004). In the present study, use of a critical feminist perspective allowed for a focused examination of the relationship between societal structures and ideologies of privilege and power as they related to the conceptualization of healthy weight and weight-management practices. Most importantly, a critical feminist lens showcased the cultural milieu in which health-related messages were delivered, as well as subsequent implications for how women experienced and lived in their bodies. Within the critical feminist perspective, the study aimed to highlight the impact of women’s lived experience residing in a thin-preoccupied society and how this interacts with experiences in a medical system that quantifies health.

My awareness of the impact of negative experiences surrounding women’s weight is anchored not only within my personal experiences of living as a woman in a Western society preoccupied with thinness, but also in the many encounters I’ve had working clinically with clients in a number of diverse settings. These have included: university counselling centres, non-profit organizations, private practice, and a hospital. Within these different settings, many women shared their experiences of weight-related dialogues that negatively impacted their lives in a number of areas, including their
psychological wellbeing. It alarmed me to hear women talk about feeling “dismissed” and “belittled,” especially within relationships that involved inequity in power. One instance that stayed with me regarded a specific woman’s experience with a health care provider. I began to wonder: What were the experiences of women receiving information or advice concerning the sensitive and value-laden topic of weight?

This was the springboard of my inquiry. Thinking about the cultural context within which weight-management interventions were provided, my goal was to more fully understand the intricacies involved in these dialogues, and subsequently, the ways in which they affected how women thought about, felt, and lived in their bodies. In line with employing a critical feminist lens for inquiry, the aim of this research project was to create an avenue for women’s voices and needs to be heard. As stated by Olesen (2000), feminist perspectives have the capability of showcasing women’s experiences front and centre, as well as the social intricacies that surround their unique experiences.

**Rationale for a Qualitative Design**

Within the social science field, qualitative methods have played an increasingly important role in scientific inquiry as a means of gathering in-depth and detailed narratives (Henwood & Pidgeon, 1992). Qualitative research is particularly useful when considering the “How” and “What” of research as opposed to the more quantitative “Why” (Creswell, 1998). Morrow (2007) wrote that when the researcher’s goal is to explore and present a rich, detailed view of the multifaceted nature of human phenomenon, qualitative research is a suitable and desirable approach. With qualitative research, a unique exploration into the complexities of human life can be accomplished,
and a greater understanding of participants’ experiences and the personal meanings ascribed to them gained (Glaser, 1999).

Many researchers advocate the importance of qualitative studies, with specific attention focused on the role of the participants. For example, in qualitative research, participants are often seen as experts and informants as they are the providers of such personal information (Miller & Crabtree, 1999). Furthermore, qualitative research methods provide access into social dialogues, beliefs, values, attitudes, and processes that constitute the main components of an individual’s experiences (Malterud, 2001). Because the current study sought to uncover the personal meanings and underlying processes within women’s experiences receiving weight-related information and advice from doctors, a qualitative methodology was warranted.

**Constructivist Grounded Theory Approach**

This study employed Charmaz’s (2006) constructivist grounded theory approach as the primary means of organizing and analyzing the gathered data. A constructivist grounded theory methodology is supported in its approach through the use of data collected from semi-structured interviews (Charmaz, 2006). Emphasis was placed on delving beyond surface-level meaning within the data, searching for the deeper underlying meanings that related to participants’ values, beliefs, and ideologies (Charmaz, 2000). Furthermore, there was a strong focus on the co-construction of meaning by participants and researcher. As Charmaz (2006) described, the researcher must immerse themselves into the data at a depth that embodies participants’ voices in the final product.
The development of Charmaz’s (2000, 2003, 2005, 2006) constructivist grounded theory derives its theoretical underpinnings from grounded theory methodology initially developed by Glaser and Strauss (1967), and later advanced by Strauss and Corbin (1990, 1998). At its simplest, grounded theory methodology can be described as a means for creating a theory that is grounded in data that has been collected and analyzed in a systematic fashion. This process is often characterized as inductive in nature as the researcher has no predetermined ideas to prove or disprove. Rather, from participants’ narratives important issues and themes emerge (Strauss & Corbin, 1998).

Charmaz later developed her model of constructivist grounded theory utilizing the traditional grounded theory’s strategies as a foundation for analysis, but rejecting the notions of the “objectivist, positivist assumptions” wherein the discovering theory emerges from the data independent of the researcher (Charmaz, 2006). More specifically, Charmaz’s theory adopts the assumption related to relativism of multiple social realities and strives for an interpretive understanding of participants’ experiences as they are lived and organized in awareness (Charmaz, 2003). In doing so, the importance of context is emphasized when grounding the data and developing the emergent theory (Charmaz, 2006). Charmaz declared that a constructivist approach to grounded theory does not provide a window on reality but rather acknowledges the collaborative construction of knowledge by participants and researcher, as well as its cultural and structural contexts (Charmaz, 2000).

Constructivist grounded theory allows for rich data collection that is detailed, focused, and full by illuminating the inner dialogues, perceptions, and feelings of participants without losing the importance of the circumstances and backgrounds from
which they came (Charmaz, 2006). As explained by Mills, Bonner, and Francis (2006), the constructivist approach to grounded theory strives to preserve the participants’ presence throughout the research process in order to obtain a richer understanding of their unique perception of the world around them. Accordingly, constructivist grounded theory affords the researcher the valuable opportunity to appreciate how participants make sense of their experiences as well as interpret their meanings and actions (Charmaz, 2006).

The principles of constructivist grounded theory lend themselves well to the criteria maintained in conducting feminist-informed research (Allen, 2011). Both standpoints advocate studying participants from their own perspectives, as they are the experts of their own experiences, as well as focusing on restructuring and minimizing the unequal power dynamics within researcher-participant relations. Through the research process, both constructivist grounded theory and feminist-informed research strive to maintain the originality and authenticity of participants’ personal experiences (Charmaz, 2003).

Within constructivist grounded theory, researchers are guided to provide participants with written summaries of their narratives following their first interview. Participants have the opportunity to review and revise their summaries in order to capture their lived experience more fully (Charmaz, 2006). In turn, the co-authoring process in constructivist grounded theory allows for a richer understanding of the women’s narratives. Lastly, both the constructivist grounded theory approach and feminist-informed research appreciate that knowledge is subjective and always partial, thus inspiring reflexivity by encouraging researchers to be attuned to their personal location, background, and biases throughout every stage of the research process (Charmaz, 2006;
Harding, 1987; Morrow, 2007). The constructivist approach to grounded theory was therefore deemed appropriate to an inquiry shaped by a critical feminist lens.

**Participants**

A total of 18 women participated in the present study. This number was based on theoretical saturation derived from the point at which further gathering of data yielded no new properties or themes (Strauss & Corbin, 1998). Saturation was met after approximately 12 interviews, which was when the narratives demonstrated no new data. However, six more interviews were conducted to confirm that no new themes emerged. One interview was conducted with each woman.

The ages of the 18 women ranged from 18 to 45, with an average age of 30 years. Of the 18 women who participated in the study, 12 were born in Canada, and six were born outside of Canada (South America, Central America, South Asia, Southeast Asia, Asia, and Africa). With regards to ethnocultural backgrounds, nine of the participants self-identified as European-Canadian (six Anglo-European, one Romanian, one Greek, and one Portuguese); three participants identified as East Asian; two participants identified as Latino; two participants identified as Middle Eastern; one participant identified as South Asian, and one as African. In terms of the socioeconomic statuses of the 18 participants, five of the women self-identified as lower, two as lower-middle, nine as middle, one as middle-upper, and one as upper class. Participants’ level of education ranged from high school through to graduate degrees.

Of the 18 participants, four of the women were married, two were common law, and twelve identified as single. Two of the women had children. With regards to sexual
orientation, 15 of the women self-identified as heterosexual, two as bisexual, and one woman did not identify with any sexual orientation group. In relation to physical or mental health challenges, five of the women reported currently dealing with medical problems; three of the participants stated they had dealt with medical difficulties in the past. Medical issues included Graves’ disease, high blood pressure, ovarian tumours, epilepsy, polycystic ovary syndrome (PCOS), and Type 2 diabetes. Additionally, five of the women reported currently dealing with mental health issues; two additional participants had reported experiencing mental health issues in the past. Reported mental health issues included depression, anxiety, as well as disordered eating and an eating disorder.

Based on Body Mass Index (BMI) categorization calculated from participants’ self-reported estimates of their height and weight during the time that they were recipients of weight-related information from their doctors, two participant had BMIs ≤ 18.5, often classified as “underweight” in medical charts; four between 18.5 and 24.9, often classified as “normal weight”; four between 25 and 29.9, often classified as “overweight”; and eight had BMIs ≥ 30, often classified as “obese” within the medical literature (Health Canada, 2011). Within those 18 participants, three of the women were advised to gain weight and 15 were advised to lose weight. Regarding the location of the doctors’ offices, 14 of the women reported that their doctors were located in urban areas while the remaining four reported that their doctors were located in suburban areas. Nine of the women’s doctors were male and nine were female. Estimated ages of the doctors ranged from approximately 30 to 60. General demographic information for the participants is outlined in Table 1.
Table 1: Participants’ General Demographic Information

<table>
<thead>
<tr>
<th>Research Name</th>
<th>Age Group</th>
<th>*Ethnocultural Backgrounds</th>
<th>**BMI Category</th>
<th>*SES</th>
<th>Education Level</th>
<th>*Sexual Orientation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ashley</td>
<td>Mid-20s</td>
<td>Euro-Canadian</td>
<td>BMI ≥ 30</td>
<td>Upper</td>
<td>Undergrad</td>
<td>Heterosexual</td>
</tr>
<tr>
<td>Clair</td>
<td>Early 20s</td>
<td>Euro-Canadian</td>
<td>BMI ≥ 30</td>
<td>Lower</td>
<td>College</td>
<td>Heterosexual</td>
</tr>
<tr>
<td>Madeline</td>
<td>Mid-40s</td>
<td>Euro-Canadian</td>
<td>BMI ≥ 30</td>
<td>Middle</td>
<td>Graduate</td>
<td>Bisexual</td>
</tr>
<tr>
<td>Mary</td>
<td>Mid-20s</td>
<td>Middle Eastern</td>
<td>BMI ≤ 18.5</td>
<td>Middle</td>
<td>Graduate</td>
<td>Heterosexual</td>
</tr>
<tr>
<td>Carol</td>
<td>Late Teens</td>
<td>African</td>
<td>BMI 18.5-24.9</td>
<td>Middle</td>
<td>High School</td>
<td>Heterosexual</td>
</tr>
<tr>
<td>Jessica R.</td>
<td>Late 20s</td>
<td>Middle Eastern</td>
<td>BMI ≤ 18.5</td>
<td>Lower</td>
<td>Undergrad</td>
<td>Does not Identify</td>
</tr>
<tr>
<td>Rose</td>
<td>Mid-20s</td>
<td>Euro-Canadian</td>
<td>BMI 18.5-24.9</td>
<td>Lower</td>
<td>Undergrad</td>
<td>Heterosexual</td>
</tr>
<tr>
<td>Les</td>
<td>Mid-40s</td>
<td>Euro-Canadian</td>
<td>BMI ≥ 30</td>
<td>Middle</td>
<td>College</td>
<td>Heterosexual</td>
</tr>
<tr>
<td>Jane</td>
<td>Late 20s</td>
<td>East Asian</td>
<td>BMI 25-29.9</td>
<td>Middle</td>
<td>Undergrad</td>
<td>Heterosexual</td>
</tr>
<tr>
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<td>Mid-40s</td>
<td>East Asian</td>
<td>BMI ≥ 30</td>
<td>Middle</td>
<td>Graduate</td>
<td>Heterosexual</td>
</tr>
<tr>
<td>Chrystal</td>
<td>Late 30s</td>
<td>Latino</td>
<td>BMI ≥ 30</td>
<td>Lower</td>
<td>High School</td>
<td>Heterosexual</td>
</tr>
<tr>
<td>Christmas Sweater</td>
<td>Early 20s</td>
<td>Euro-Canadian</td>
<td>BMI 25-29.9</td>
<td>Middle</td>
<td>Undergrad</td>
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</tr>
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<td>Juliette</td>
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<tr>
<td>Jessica W.</td>
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<td>Bisexual</td>
</tr>
<tr>
<td>Nine</td>
<td>Early 20s</td>
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<td>Middle</td>
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</tr>
<tr>
<td>Joyce</td>
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<td>Lower</td>
<td>High School</td>
<td>Heterosexual</td>
</tr>
<tr>
<td>Emily</td>
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<td>BMI 18.5-24.9</td>
<td>Middle</td>
<td>Undergrad</td>
<td>Heterosexual</td>
</tr>
</tbody>
</table>

* Participants’ self-identification
** BMI calculated from participants’ reports of weight and height at the time of their doctors’ weight-related advice. Canadian Guidelines for Body Weight Classification in Adults, as per Health Canada (2011), classify BMI ranges in the following way: Underweight (BMI < 18.5); Normal Weight (BMI 18.5 to 24.9); Overweight (BMI 25 to 29.9); Obese (BMI ≥ 30)
Procedure

In order to gain diversity among participants, recruitment took place within urban and suburban areas of southwestern Ontario. Advertisements (see Appendix A) were placed on list serves, community boards, and online public posting sites (e.g., Kijiji and Craigslist). Inclusion criteria were clearly outlined and consisted of: (1) being a female between the ages of 18 and 25; (2) attending an annual physical exam with a GP within the last two years; and (3) receiving some form of weight-related information, feedback, or advice. No other exclusion criterion was applied. Women who were interested in participating in the study were required to respond by telephone or email for further information, and to set up a telephone screening (see Appendix B). During the telephone screening, the researcher contacted interested women to determine their willingness to participate and to ensure that they fit the selection criteria.

Women who met the criteria were invited to participate in the study and were informed that participation would include a one-to-two-hour interview, and the potential for a second interview, as well as approximately one hour of their personal time to review the interview transcript and summary. They were also informed that they would receive a $20 gift card for compensation at the completion of the interview. Contact information was then collected and an electronic copy of the Informed Consent Form (see Appendix C), defining the limits of confidentiality, procedures for file storage and security, benefits and risks associated with participating in the study, as well as their right to withdraw from the study at any time void of penalty, was emailed to interested individuals. They were then asked to contact the researcher once they had reviewed the consent form carefully and had made an informed decision pertaining to participation in the study. If
they had any questions, the researcher provided clarification for them at that time. An established date, time, and meeting place was then organized with the women who agreed to participate in the study.

The Interview

Eighteen interviews were conducted in total—17 face-to-face and one telephone interview. Options for the interview setting included a private room in the OISE Counselling & Psychoeducational Clinic at the University of Toronto, the participant’s home, or in another location of the participant’s choice; 17 participants chose the private room in the OISE Counselling & Psychoeducational Clinic at the University of Toronto and one participant chose to participate from her home. Because the goal of the interview was to understand the participants’ experiences, gaining trust and establishing rapport was the number one priority (Denzin & Lincoln, 2003). Before beginning the interviews, the researcher provided participants with a hard copy of the Informed Consent Form (Appendix C) that outlined, once again, the purpose and nature of the study as well as the limits of confidentiality. Participants were also provided with a Request for Summary of Research Findings form (see Appendix D), in the case that they would like to receive a written report of the research findings upon completion of the study. The researcher talked with participants about how participation in the study may involve re-experiencing certain distress and invited them to monitor and share any such distress with the researcher. In addition, the researcher provided a list of contact information for counsellors should the participant need additional support (see Appendix E).
After consent was obtained, the researcher invited participants to choose a pseudonym that was used throughout the research process in order to maintain confidentiality. The participants’ pseudonyms were used in all transcripts and summaries, and all identifying information from the interviews was removed. Interviews ranged from 60 to 90 minutes. All interviews were digitally recorded. Interviews focused on participants’ experiences receiving weight-related information or advice from their doctors. In each interview, an Interview Questioning Guide (see Appendix F) was used to ensure adequate probing and collection of information. However, in order to gain a greater breadth and understanding of participants’ experiences, the researcher was cognizant of following each participant through their personal recollections of weight-related experiences.

Upon completion of the study, the researcher thanked the women for their participation and provided them each with a $20 gift card. After the interviews were completed, digital recordings were directly transferred to an encrypted computer file that was password-protected on the researcher’s computer, and the original MP3 recordings were deleted. A professional transcriptionist was hired to transcribe the audio recordings. A written summary was prepared, detailing each of the participant’s narratives, which was then sent along with the transcription of the interview for each participant to review, in order to receive clarifications or revisions where necessary.

**Data Analysis**

Constructivist grounded theory approach was used to code and analyze the data in the current study. Throughout the course of data collection and analysis, a grounded
theory process called “memo-writing” was implemented to maintain notes on observations, interpretations, and emerging hypotheses related to how the data may be connected theoretically (Charmaz, 2006). Credibility was thus enhanced by the use of ongoing observation through memo-writing. Further, memo-writing assisted in the use of theoretical sampling. Theoretical sampling involved starting with the data, building tentative hypotheses, and subsequently investigating these ideas through further empirical investigation (Charmaz, 2006). In Charmaz’s (2006) description, “theoretical sampling helps you to check, qualify, and elaborate the boundaries of your categories and to specify the relations among categories” (p. 107). Accordingly, data collection was guided by theoretical sampling in order to assist in constructing full and robust categories.

With regards to data analysis, upon completion of the transcription process, the researcher carried out in-depth readings of participants’ interviews. During this process, descriptive codes were ascribed to line-by-line units of text in the margins, with the aim of highlighting all possible meanings presented in the narratives. In turn, these descriptive codes assisted with the creation of an initial coding tree, illuminating lower-level themes as they appeared across the interviews. A constant comparison method was used to produce higher-level themes once the original coding tree had been reviewed and validated by the researcher’s supervisor. Core categories, categories, themes, and subthemes related to participants’ experiences were identified by carefully examining similarities and differences across interviews. The final coding scheme was examined, discussed, and accepted by the researcher’s supervisor (see Appendix G). Interviews were then coded into categorically comparable data sets according to the final coding scheme using Microsoft Word.
Based on participants’ narratives, a hierarchical structure was developed with three core categories depicting women’s experiences with weight-related dialogues from their doctors: Weight Weighing on the Doctor-Patient Relationship; Patients’ Self and Body Experiences; and Practice (see Figure 1).

**Figure 1.** Core categories emerging from the study

Chapter 3 will present results for Weight Weighing on the Doctor-Patient Relationship. In Chapter 4, results for Patients’ Self and Body Experiences will be presented. And Chapter 5 will present results for the final core category, Practice. With regards to descriptor terms, participants in the present investigation are referred to as “participants” throughout the manuscript. However, in citing other research studies, the label “patients” is often used to describe research participants. In addition, when referring to the descriptions of doctors’ recommended practices provided by the participants in the present study, their own terms—often “patients”—are used.
CHAPTER THREE

WEIGHT WEIGHING ON THE DOCTOR-PATIENT RELATIONSHIP

“Words hurt.”
Les

Chapter 3 examines the first of the three core categories that emerged from the analysis, specifically Weight Weighing on the Doctor-Patient Relationship. Under this core category, four categories emerged: Weight and Power in the Doctor-Patient Relationship; Weight in Context; Weight and Health in the Medical Room; and Meaningless Scripts (see Figure 2).

*Figure 2.* Categories and themes emerging from first core category Weight Weighing on the Doctor-Patient Relationship
**Weight and Power in the Doctor-Patient Relationship**

Weight and Power in the Doctor-Patient Relationship emerged as the first category under the first core category of Weight Weighing on the Doctor-Patient Relationship. This category included five themes that demonstrated how weight affects the doctor-patient relationship, as well as how weight and other factors play an intricate role in the power dynamics inherent within this relationship. Themes within this category included: Unsolicited Advice; Delivery of Weight-Related Dialogues; Expression of Negative Stereotypes Regarding Weight and Bodies; Loss of Voice; and Importance or Trust Placed on Doctors (see Figure 3).

![Figure 3: Themes pertaining to the category Weight and Power in the Doctor-Patient Relationship](image)

**Unsolicited Advice**

Under the first theme of the Weight and Power in the Doctor-Patient Relationship category, entitled Unsolicited Advice, the majority of participants \((n = 14)\) discussed receiving some form of Unsolicited Advice from their doctors. Different situations emerged from participants’ experiences related to Unsolicited Advice. For example, four women talked about their doctors directly advising them to lose weight.
I had a family doctor earlier on who raised it as an issue without me even mentioning it . . . he goes, “You know you’ve been overweight for a while,” and I was like, “I have,” and he goes, “You probably could stand to lose about 20 pounds” . . . I didn’t even ask him. It made me so uncomfortable and self-conscious and angry . . . it’s clearly not related to a direct medical issue, and when they problematize it without taking other factors, when they see it as the issue as opposed to part of a holistic picture, that’s a real problem for me. (Madeline, age 44)

He checked me and then he just said, “You’re overweight, lose some weight” . . . I was quite shocked because my mom hadn’t even brought that kind of thing up before . . . I’d never been exposed to such talk before, so for someone to just tell me that I had to lose weight, it was weird for me. I knew about being fat and obese but I didn’t think I was approaching that mark . . . I wasn’t comfortable with him anymore because of how he just openly said such a thing. (Carol, age 18)

I realized maybe I shouldn’t be this big, like he’s telling me for a reason. I guess he goes by his standards. He told me, “You’re supposed to be weighing 140 for your height,” and I was like, “What, in one leg?” Oh God. I felt like crap. I cried. Oh my God, sorry yeah that just brought me back. But, yeah, it was horrible. (Chrystal, age 37)
Participants also described being directed to “do more” in relation to the theme of Unsolicited Advice.

They just bark stuff at you. When I went to the doctor I didn’t bring it up ’cause I never do but they’re never happy. It’s like I’ve already lost some weight on my own, now you say, well you got to do more and try harder. (Clair, age 42)

I said, “Well to be honest, I’ve actually lost 24, after I’d seen you I’d gained a bit more but then I lost it.” He goes, “You gained that much weight?” And I said, “Yeah,” and he goes, “Okay, well good start, you’ve still got a road ahead of you, keep going.” I thought, you’re a dick. I just thought, you’re really insensitive. (Madeline, age 44)

I felt like I wish that she’d sort of given me some positive reinforcement for the strides I’d already made instead of just being like, “You have to do more,” and I was like, “I’m already trying” . . . I had been losing weight in the past so I felt like she doesn’t even see that my progress is coming along and she didn’t really congratulate me on losing weight. (Jessica W., age 22)

In their interviews, three of the women spoke of receiving unsought instructions from their doctors to gain weight.
It’s not like I’m coming in complaining about my weight or anything like that, I could be coming in for a cold or a vaccination and it’ll be like, “Oh you look thin.” The comment will be made a lot of the times from observation. It’s always like, “Oh you’re so thin, you should put peanut butter on everything, gain a couple of pounds” . . . It immediately goes to you having an eating disorder because the rest of us have such a hard time losing weight it must be that you’re starving yourself, how could you possibly be this small. (Mary, age 26)

He started talking to me, “Oh one thing I did want to mention is your BMI is below even the low for females.” And so I explained to him, “Well in my family a lot of us are like that. We’re skinny no matter how much we eat. I don’t diet or anything like that.” And he kind of insisted, “But it is too low, you should eat more.” . . . I didn’t ask for his advice, I didn’t want it, I didn’t even think it was an issue so I would never bring it up to a doctor. (Jessica R., age 27)

A few other participants (n = 3), including Chrystal and Jessica, discussed how their doctors provided unsolicited opinions and evaluations regarding their bodies in relation to being a woman.

I didn’t see him for a long time so he’s like, “Oh you’re looking pretty healthy,” and I’m like, “Okay, you mean I’m getting fat?” Because I already knew I gained weight and he would just be like, “Yeah, you’re getting heavy . . . you got to take
better care of yourself and your body image, your husband wants to keep you pretty.” (Chrystal, age 37)

He’s like, “If you eat more, you might find that parts of your body that are less feminine might become more feminine.” I mean I don’t think that’s actually even true what he was saying, whether it’s appropriate or not. . . . In my mind it’s like I didn’t take him seriously at all because I knew that’s not how it works, and in any case, it’s a weird way for him to try to convince me. (Jessica R., age 27)

One participant discussed the positive experience she had when her doctor did not bring up her weight or provide unwelcome advice.

I appreciated the balance between her not raising it as an issue unless I did, and technically my weight falls within the obese range. It didn’t disrupt care. It made me okay to go in and talk to her. I felt as though I wasn’t always being looked at as a number on a scale; I felt as though she had a holistic picture of my health, she took my concerns about weight seriously when I raised them without her being alarmist around them, and without her being controlling of my body. There was a real joining in the conversation. (Madeline, age 44)

**Delivery of Weight-Related Dialogues**

Under Delivery of Weight-Related Dialogues, the second theme of the Weight and Power in the Doctor-Patient Relationship category, participants discussed a number
of different encounters related to how doctors delivered messages surrounding weight, all of which appeared to elicit strong emotional reactions. For example, 13 of the women interviewed described instances when their doctors delivered weight-related messages in a cold, forthright, or harsh manner.

The fact that he let me know I was overweight, I was like okay, but he came off harsh . . . to me it was like a slap in the face like what, get to 135 pounds and I’m weighing like 200 pounds, are you kidding me? It came off harsh. (Chrystal, age 37)

It was a little cold and insensitive because she has known me for a while, I felt like she could have eased into it a little bit just knowing that I have struggled with my weight my whole life, but I don’t know, she’s a doctor, right, so I get that at some point you have to sort of come out and say it. (Jessica W., age 22)

As a physician I can understand it’s just something that could potentially be concerning, but I remember distinctly that I’m like, oh my gosh, why would you tell me this, now I feel really bad. And the way she conveyed it was very straightforward. I don’t want to say it was a personal attack on me—again this could be just how I’m interpreting—but I wouldn’t say it was a positive way to handle it. When it is briefer, when you discuss it less, it doesn’t seem like the doctor cares as much. It’s like, this is your problem, deal with it. (Rose, age 23)
Approximately half of the participants \((n = 8)\) talked about their doctors’ delivery of weight-related dialogues coming across as inappropriate and unprofessional.

I think it was very unprofessional, it was very insensitive. People who struggle with weight, you throw that in their face and it just doesn’t help. We have low self-esteem to begin with. Any type of effort that you do put toward it, good thing I’m not sitting in front of you, holy shit. [Tearing up]. And I’m a girl. I’m not looking for hugs and oh poor you, but even an element of professionalism ’cause that was not professional . . . there was no doctor-patient relationship, there was no therapeutic relationship, and that’s what is the most important. (Les, age 45)

In my experience, doctors are very direct and very blunt, so saying things like, oh you’re so thin, put peanut butter on something, that’s not even a case of direct, that’s just rude. I felt like it was really unprofessional . . . there was nothing medical about the consult, there was nothing professional about it . . . that to me is rude, the way things were articulated. (Mary, age 26)

Just under half of the participants \((n = 6)\) talked about the delivery of doctors’ weight-related messages as being demeaning, belittling, and/or condescending in nature.

Their delivery is pretty condescending. And of course they’re usually a little bit taller than you, you’re sitting down, so it’s like that whole parental type of disciplinarian, the way your parents tried to keep you from eating sweets or
whatever and then you overcompensate when you’re an adult, that whole power
difference. (Clair, age 42)

There was this desk in between us and the delivery, it’s almost like your
principal’s office and they’re finger-wagging and you don’t have any intimacy
there, whereas with my other doctor he would always turn his chair, sit at your
level and deliver everything, not necessarily intimately, but there was a
connection. (Christmas Sweater, age 22)

I guess not being aware enough about what might be going through my head, and
only seeing it from his perspective and looking at me like I’m a child or
something, ’cause it really felt like that. I’m 27 years old but it felt like he was
treating me like I was a kid. It just reconfirmed in my mind that some doctors, no
matter how much training they get, the way he communicated was not convincing
at all to me, just condescending, and as if I didn’t know at all what was best for
myself. If it was a different doctor, and the way he explained it and his body
language was different, I could have potentially taken it more seriously. (Jessica
R., age 27)

Conversely, only three participants discussed times in which the delivery of weight-
related messages was provided in a positive manner, conveying gentleness, sensitivity,
and room for conversation.
With my other doctor it was a completely different story. He’s a lot more gentle, there’s a lot more discussion about how you’re feeling, very into the psychological impact of all these types of things. We talked a lot about how I was feeling about it . . . everything is really addressed with extreme sensitivity . . . you feel like you actually have a voice and that somebody cares, somebody is taking care of you. (Christmas Sweater, age 22)

I thought everyone was supposed to look a certain way; I still do, but she said apparently you’re supposed to gain weight and everything has to grow until you’re 21, and I was really surprised about that so that was actually very helpful, the validation that gaining weight was healthy. Also she let me talk, that was the most helpful thing . . . that was very positive. (Joyce, age 18)

**Expression of Negative Stereotypes Regarding Weight and Bodies**

The third theme of the Weight and Power in the Doctor-Patient Relationship category, entitled Expression of Negative Stereotypes Regarding Weight and Bodies, showcased participants’ experiences pertaining to negative stereotypes about women and weight. All but three of the participants ($n = 15$) perceived some discussions with their doctors as enforcing negative stereotypes about weight and body size. For example, half of the participants ($n = 9$) felt as though their doctors believed they were to blame for their weight, reflecting stigma about overweight individuals being out of control with their eating.
Just their attitude, the way they look at you, it’s like they think you don’t give a
shit, so they develop that prejudice and I think they just hold it against you
because they think you’re not trying . . . you put the food in your mouth, you buy
the food, you do the shopping, you know what you are doing to yourself, you
don’t take care of yourself . . . it’s just a general vibe that you get with a lot of
doctors. (Clair, age 42)

I did feel it was like, you brought this on, you fix it. It was kind of the implication.
It was almost like fat people are to blame, especially fat women, right, ’cause
larger men can be linebackers, that’s awesome, but if a woman’s obese it’s like
you ate cheesecakes. There were a lot of assumptions, and I also found, too, it was
like, you wanted to eat this didn’t you . . . the way to deal with a larger person
isn’t by yelling or shaming them . . . you’re not going to get anywhere by shaming
someone out of eating. (Ashley, age 23)

Eight of the participants discussed situations where they felt shamed for their
weight, relating these experiences to their doctors’ own stigma or personal biases about
overweight bodies.

They’re not given training on these sensitive issues, they just hit people over the
head with the moralism of medicine, which I think has replaced the church
personally in our society, and what’s left is their personal biases and they come
through in the guise of medicine. That’s my take on it. So the doctors who
shamed me had issues with weight and that’s getting transposed through a lab coat. If I sense that then I don’t take them that seriously, I just stop going and seeing them because I think they’re bad doctors. I don’t want to be fat-shamed just like I don’t want to be any-shamed. (Madeline, age 44)

It’s such a common response, I think, especially with my experience with male doctors in that yeah, your weight is everything . . . because there’s that stigma about being overweight, there is always that element, he was borderline disgusted. That’s how he made me feel, it still upsets me. I didn’t go back. (Les, age 45)

Whereas Madeline and Les felt shamed for being overweight, Mary conveyed the shame she felt for being underweight and how she was affected by the stigma that associates underweight bodies with an eating disorder.

What I don’t understand is how people can differentiate somebody who’s thin and ill and somebody who’s just thin because they’re just thin . . . I feel like everything I do is scrutinized under the impression of an eating disorder … as soon as there’s a deviation from something it’s oh, it must mean eating disorder. There’s the genetic disposition for my size but the doctor doesn’t care . . . it’s, I’m just looking at you, you don’t look appealing, so put weight on. (Mary, age 26)

Madeline and Christmas Sweater were the only two participants who spoke of experiences where particular doctors did not shame them for their weight. They perceived
that the interactions reflected their doctors’ freedom from biases about weight, focusing instead on the most pertinent issues related to their health.

I said, “Is my weight an issue?” And he goes, “Your weight is not an issue for me,” and I was like, “Wow” . . . I felt as though my health was being treated and not my fat . . . he could have used that as an opportunity to fat-shame me and he didn’t, so they’re not levelling that kind of moralism at me and it is positive.

(Madeline, age 44)

My GP basically told me, “It’s a moment in time, it’s not forever . . . you’ll bounce back and you’ll see an improvement and you’re going to feel so much better.” So that was always positive, ’cause you kind of forget, like you really get entrenched in that negativity and basically the explanation that it’s not your fault . . . hearing that is helpful. (Christmas Sweater, age 22)

**Loss of Voice**

Under the theme Loss of Voice, the fourth of the category Weight and Power in the Doctor-Patient Relationship, just under half of participants (n = 7) described situations where they felt dismissed by their doctors or not viewed as truthful regarding their weight issues or body practices.

I felt like I wasn’t being taken seriously . . . I didn’t know what to tell him, but in the end I kind of agreed with him and I’m like, oh okay, ’cause I knew no matter
how much I already told him there are people who do fall under that category but they’re still healthy, he continued to lecture me the whole time . . . he didn’t think I knew what was best for me and I think the original reason I came there he didn’t take that seriously at all. (Jessica R., age 27)

I’m like weeping in her office and it was kind of like there was no recognition of that, so I felt like she was being pretty cold and I felt like my thoughts were not received and I felt like there was no airtime given to what my concerns were . . . I felt like I’ve not been treated well and that’s not okay . . . you just feel like you’ve been kicked around and I just felt like she was dismissive of all my concerns so yeah, I had to stop with that. (Christmas Sweater, age 22)

I felt awful, I felt like you didn’t even care to figure out why this happened or anything, just the fact that a female is fat therefore it is her fault, like she’s responsible for fixing it as an adult . . . I felt like a specimen. I just felt like I regressed, I felt like I’ve lost my rights, like would people, if I was thinner, have a nicer conversation with me? If I was thinner, would my feelings matter more? (Ashley, age 23)

**Importance or Trust Placed on Doctors**

Under the fifth and final theme of the Weight and Power in the Doctor-Patient Relationship category, entitled Importance or Trust Placed on Doctors, a number of participants ($n = 9$) conveyed the importance they placed on doctors’ advice and
knowledge. This, in part, elucidated the power of doctors’ messages surrounding weight. For example, several participants ($n = 6$) talked about placing a lot of significance on their doctors’ instructions surrounding weight management, which in turn, impacted the importance of the message.

When my doctor talked to me about losing some weight it really struck me as odd ’cause I never saw myself as someone who really needed to lose weight. For him to have brought that up, it meant something big. I really place high emphasis on what doctors tell me; the doctor is someone whom I should trust. (Jessica W., age 22)

I think it kind of took me back about how serious this was and how my weight was a problem that I didn’t realize. It was kind of like a wake-up call. I was just kind of concerned and I was like, okay, I need to get this under control because it came from my doctor. It’s one thing when you go to a store and you’re like, okay, this doesn’t fit, but it’s another to hear it from your doctor . . . I feel with the doctors you know that they’re coming from a place of knowledge. (Nine, age 22)

There’s a lot of stuff on the Internet you can find about what’s healthy, it’s amazing, but you trust your physician more, right, which is why you go to your physician, so it would mean more if I got diet advice from my doctor . . . you trust your physician because they know you and obviously they’re a doctor for a reason. (Rose, age 23)
In particular, Les talked about how she perceived that many people accept what their doctors tell them without question.

If your next research was about taking doctors’ advice [laugh] and especially when you’re more elderly, people hang off of their doctor’s every word. It is a profession where people hardly challenge what their doctor says. It is a profession where the elderly won’t even consider a second opinion. They [doctors] have such an incredibly powerful opinion, a powerful place in society, and some of them have the complex to go with it, and what they say is very, very powerful. (Les, age 45)

Christmas Sweater talked about how the importance she placed on doctors’ advice has shifted over time.

At first I was like, I trust the expert, and then after I went through that I was like, you know what, screw this lady, she doesn’t know what she’s talking, I sort of lost my faith, and then when I went to see other doctors it kind of came back. (Christmas Sweater, age 22)

Madeline discussed her appreciation for her doctor’s transparency with respect to the training doctors receive in medical school and the dilemma inherent in dealing with weight-related issues.
She will openly admit that and she said, “It’s a real problem . . . as doctors we don’t know what to tell patients because they come to us as a real source of information, and we don’t receive any training in med school on it.” And that’s what I appreciate about my family doctor. She’ll say, “I’m not an expert in weight, let me send you to people who are.” (Madeline, age 44)

**Weight in Context**

Weight in Context emerged as the second category, under the first core category of Weight Weighing on the Doctor-Patient Relationship. Under this category, four themes emerged: (No) Exploration or Importance Placed on Social Location; (No) Exploration or Importance Placed on Biological, Medical, or Psychological Histories; (No) Exploration or Importance Placed on Participants’ Individual Lifestyles; and (No) Exploration or Importance Placed on Other Variables Contributing to Presenting Medical Concerns (see Figure 4). This category included participants’ perceptions of their weight not being viewed in the context of distinctive factors, and how these experiences interacted with the doctor-patient relationship.

*Figure 4. Themes pertaining to the category Weight in Context*
(No) Exploration or Importance Placed on Social Location

Under the first theme of the Weight in Context category, entitled (No) Exploration or Importance Placed on Social Location, two thirds of the participants ($n = 12$) discussed instances where they perceived a lack of consideration for their social location when dialoguing with their doctors about weight issues. Social location included socioeconomic status (SES), ethnicity, and gender. For example, five of the participants felt that their socioeconomic status was not reflected in their doctors’ prescribed weight advice. Specifically, Clair, who considered herself within the low SES bracket, Jessica W., who considered herself within the low-medium SES bracket, and Les, who considered herself within the medium social class, all felt a lack of consideration related to the cost that pursuing their doctor’s weight-management instructions would entail.

They [doctors] think everybody makes what they make . . . they can afford organic groceries. I think I was paying eight bucks for a carton eggs because it’s supposedly cholesterol-free. So they don’t consider cost or socioeconomic finances. You’re going to buy food that’s going to fill you up . . . everybody’s frantic nowadays and the economy is not that great and let’s face, it if you want to eat really healthy it’s expensive. (Clair, age 42)

Overall, I felt like she could have probably considered my input a little bit more. . . I was in school and I really didn’t have a lot of money, and I think that that contributed to the weight gain ’cause I was stressed all the time and it’s difficult to make sure you’re buying fruits and vegetables . . . in the end the options she
suggested were more like joining a gym or a community centre, and at the time I really didn’t have the money for it. (Jessica W., age 22)

I understand there are lots of programs, you know there’s Weight Watchers, there’s Bernstein, there’s Jenny Craig, there’s all these places, but they cost an arm and a leg. They [doctors] don’t seem to get that. (Les, age 45)

Under this theme of social location, some of the participants talked about their experiences involving a lack of exploration or importance placed on their ethnicity within the context of weight. For example, Mary, who is of Sri Lankan background, and Clair, of Portuguese background, discussed the lack of consideration for their ethnic backgrounds.

It seems like doctors are just always pushing the BMI scale, but I don’t think they take ethnicity into consideration ’cause not everyone is built the same way. There’s the genetic disposition for it, but then it’s like the doctor doesn’t care, they don’t consider that, and so it’s just a case of, oh well you should be this weight and as long as you’re not that it must be because you’re starving yourself or you’re not being healthy. (Mary, age 26)

With all of the different backgrounds in my family, we love food, right [laugh]. I mean the Portuguese side of my family . . . it’s a cultural thing, and that’s the other factor that doctors don’t look at. They don’t look at your cultural
background. Like for ethnicity, if you look at Asian cultures their food is the greasiest most sodium-loaded food ever and yet they’re slim. Why? Because that’s their ethnic race. Some cultures, no matter what they eat they will retain a certain look, and other cultures, I mean there are people in my family that are probably 500 pounds. (Clair, age 42)

Furthermore, several participants \(n = 5\) described experiences where they felt their doctors neglected to consider the importance of gender in their weight-related dialogues.

I often wonder about doctors, like male doctors, if they clearly understand that, no matter what, males and females are very different, and a man can look at a man and go, “Hey, you put on some weight,” or whatever, but it’s not going to be the same effect as it is with females . . . there should be an element of sensitivity training or understanding that you know, wow, words hurt. (Les, age 45)

I think there needs to be an understanding that, regardless of where you fall in the spectrum of weight, that weight in general is a sensitive topic, particularly for women, so just be sensitive about how to approach it. (Mary, age 26)

On the contrary, Madeline discussed the positive experiences she had with her female doctor, who she felt understood women’s bodies from relatable personal experiences.
My family doctor now, being a woman, I’ve seen her body go up and down, all different sizes, you know she’s been pregnant, she’s lost weight, she’s gained weight . . . she’s never been thin, she’s never really been super overweight. I think she’s just very aware that women’s bodies fluctuate. (Madeline, age 44)

(No) Exploration or Importance Placed on Biological, Medical, or Psychological Histories

Under the second theme of the Weight in Context category, 13 participants discussed experiences where they perceived their doctors to have neglected the larger context of their weight-related issues, embedded in either biological, medical, or psychological histories.

There are very strong selection processes at work in the profession and I doubt she [the doctor] had experienced certain barriers herself. This entirely ties into the inability of the Western medical establishment to take on a biopsychosocial approach to health. You must have contact and awareness with problems to be able to have a balanced perspective and balanced answers. Most doctors and policy makers in the health field are privileged and have not experienced things first-hand. I think definitely considering the social and psychological aspects to it, which was not the case in that particular instance. (Blank, age 24)

I just thought not all weight loss or weight gain is related to food . . . is it hormones or genetics? Half the family is overweight, half the family isn’t . . .
when the doctors push food and it’s never anything else like your genetics or your endocrinological system or your metabolism, it’s always you and the food, a controllable factor, and that’s what they push. . . . I mean I think you have to look at how people just emotionally feed themselves and there’s so much guilt about food. It’s always the same, the onus is always on you and there’s never any consideration for external issues or stresses in your life. (Clair, age 42)

(No) Exploration of Participants’ Lifestyles

Under the third theme of the Weight in Context category, entitled (No) Exploration of Participants’ Lifestyles, all 18 of the women interviewed described experiences where they perceived a lack of consideration or exploration of their individual lifestyles when dialoguing about weight-management approaches with their doctors.

I felt like my weight had been unnecessarily problematized and all the other good things I was doing, like going to the gym, I don’t even think he knew . . . I think there were assumptions made and he just didn’t collect enough data. It was kind of like saying to someone, I think you have pneumonia, just because they’ve got a cough, without all of the other corroborating information and that’s what was missing in that moment . . . it’s not as though I’m sitting there with diabetes, I just had a good physical done, I felt problematized. (Madeline, age 44)
I was still a student. This happened in the last year and I was busy . . . you’re always sitting. And you have to stay up late at night . . . I think the fact that I am where I am today is a lot because of my lifestyle. I go to school, I come back, I study . . . that was not considered. (Nine, age 22)

(No) Exploration of Other Variables Contributing to Presenting Medical Issues

Under the fourth theme of the Weight in Context category, 12 participants discussed their perceptions of doctors having narrow views regarding their various medical conditions. More specifically, participants talked about doctors viewing weight as the primary cause of their ailments, as well as the solution for any current medical issues.

They’ve just completely used weight gain or weight loss as your diagnosis for everything . . . because they figure that that’s what’s causing everything else. You’re tired, it’s your weight. Your medication is not too effective, it’s your weight. You can’t sleep, it’s your weight, it’s everything . . . maybe there’s a grain of truth to it but there’s always some underlying problem. Stress, work, money. (Clair, age 42)

I’ve had a lot of pain and discomfort with these cysts and I’ve had some nerve pain down my leg and he said it was attributed to my weight . . . it’s so common, weight is everything. Yet I go to a chiropractor and, low and behold, I don’t have that nerve pain down my leg anymore ’cause it wasn’t weight . . . I would be more
accepting if I had some of those issues that come along with weight, like high cholesterol, Type 2 diabetes, all those kind of classic signs of being overweight. I’m none of that, absolutely not. I am just a person who struggles with weight and has always struggled with weight and can’t seem to get a grip on as to why. (Les, age 45)

**Weight and Health in the Medical Room**

Weight and Health in the Medical Room was the third category under the first core category of Weight Weighing on the Doctor-Patient Relationship. Under this third category three themes emerged: Assumptions About Health and Weight; Role of Doctors in Weight Management; and Patients’ Understanding of Doctors’ Constraints (see Figure 5). Encompassed in this category are participants’ perceptions of their doctors’ views on weight-related health as well as their personal understandings of the involvement doctors should have in weight interventions. This category also addresses participants’ descriptions of the barriers that doctors are up against in the medical system.

*Figure 5. Themes pertaining to the category Weight and Health in the Medical Room*
Assumptions About Health and Weight

Under the first theme of the category Weight and Health in the Medical Room, entitled Assumptions About Health and Weight, all 18 participants discussed their perceptions that their doctors’ communications implied assumptions that health and weight were correlated. For example, every participant talked about how her body size was used as an indicator of her health status.

He really equated weight with health and, I mean prejudice in that he labelled it as a health issue when everything else was coming back completely healthy and I was active and I was muscular. (Madeline, age 44)

I think my doctor felt that weight was a very central determinant of future health. She seemed very determined that I should lose weight regardless of all the positive health behaviours I was reporting. (Blank, age 24)

Most participants ($n = 15$) also had experiences where BMI was used as a primary measure of their overall health.

I think my doctor believes healthy equals fitting within BMI guidelines. It was something he always brought up when discussing weight, and whether or not the weight was healthy depended on it falling within the proper BMI limits. (Jane, age 27)
The impression I get from her over the years is that in order to be healthy you need to fit into these defined brackets. And if you’re straying from this that is bad . . . there’s a healthy BMI to have and unhealthy ones. My physician just has these gold standards and she doesn’t like seeing differences. (Rose, age 23)

Six of the participants talked explicitly about questioning the BMI measure as an accurate representation of health and wellbeing.

I told him I had lost some weight and he was like, “You do need to do more because of your BMI,” which is the whole metric system, which I don’t even agree with but people still use it so if you’re a normal BMI, I’d be a telephone pole . . . I mean the doctor thinks I should probably lose 50 or 60 pounds, which is a lot, it’s all arbitrary. (Clair, age 42)

I think he probably had the book’s view of it, it just seemed like, “oh you don’t fall under this chart so you’re unhealthy” kind of thing, and in my experience those charts are not always accurate. They don’t take into account that some people are different . . . it just doesn’t make sense to me. (Jessica R., age 27)

Emily and Mary talked about how they believed that doctors should consider how ethnic backgrounds are reflected in BMI brackets for health.
I found out that apparently people of my ethnic group, that our healthy BMI limit is actually 23 not 25 because we have a smaller bone structure and we tend to store more weight in the stomach region. So any BMI over 23 is linked to increased issues and I was just thinking it’s complex. (Emily, age 37)

It seems like doctors are just always pushing that particular BMI scale, but I don’t think they take ethnicity into consideration, too, ’cause not everyone is built the same way. (Mary, age 26)

Within the context of describing doctors’ tendency to equate weight with health, participants also discussed their own views on what it meant to be healthy. Most of the participants ($n = 15$) described how their conceptualizations of what it meant to be healthy incorporated both physical and mental aspects of their wellbeing, as well as a sense of balance in life.

I think healthy means having a healthy mindset about your life meaning, wanting to be part of your life, wanting to participate in whatever your relationships are, wanting to do your academic pursuits, having a balanced life, working hard but also understanding that you should go out with friends or engage with your family or go get a pedicure because you want to. (Ashley, age 23)

I believe in mental health. I think a lot of people don’t have enough self-care in their life, but your physical health is a big part of that. You take care of your
body, it helps you take care of your mind, you feel better after exercising even if you don’t necessarily gain any direct benefit . . . a healthy person would be someone who understands all of those aspects, the importance of a good diet, having some regular physical exercise, and taking care of themselves mentally, but never goes into extremes about anything. (Rose, age 23)

I think healthy means beyond not being sick . . . it’s about being able to perform certain things physically and also being able to endure certain things emotionally. (Blank, age 24)

Two participants described shifts in the way they saw the relationship between weight and health. Joyce, who openly discussed her struggles with an eating disorder, talked about how her current perception of health encompassed much more of a focus on weight and body size than it did prior to struggling with an eating disorder.

Healthy to me is not being fat, that’s one big thing. Personally, I feel health depends a lot on how much you weigh . . . I think probably my perception of health was more accurate at the beginning, like I can recognize that sometimes what I say doesn’t always make sense, but it makes sense to me . . . before everything I don’t think it mattered as much. I didn’t focus nearly as much on weight. I just thought it meant as long as you don’t have any heart problems or high cholesterol, pretty much as long as you’re living your life to your fullest so
that you’ll be able to live a long life, that was what health was to me before. Now it would be more on what you weigh. (Joyce, age 18)

Carol, on the other hand, described how moving to Canada from Nigeria led to her viewing health independently from weight.

My view of health when I was in Nigeria was being big, being fat. That’s what I thought it was, because as long as you ate and you had fat cheeks and big boobs, that was the ideal, because it meant that you were eating a lot, it meant that you were rich, living the life, that was my ideal of health, but now . . . being able to do every single thing you want to do and not feeling tired at the end of the day is healthy, having the stamina to do whatever you want to do. (Carol, age 18)

**Role of Doctors In Weight Management**

Under the second theme of the Weight and Health in the Medical Room category, entitled Role of Doctors in Weight Management, participants discussed their views on what they believed the role of a doctor should be within the weight-management domain. Many participants ($n = 10$) talked about how they expected their doctors to note fluctuations in their weight or to bring up weight *only* if it was related to a medical concern.

I think it’s definitely important for a physician to keep note of fluctuations in weight in either direction, either a significant gain or significant loss, but in terms
of just pure weight gain and weight loss, I don’t think that should necessarily be an issue as long as they’re living a healthy lifestyle, I think that should be the first thing that’s investigated. (Rose, age 23)

I think if they do see I’m below average that’s definitely a reason to bring it up, but if I tell them clearly I eat whenever I’m hungry, I eat healthy, I exercise, I have other siblings in my family who are also skinny, I expect it to kind of just end there unless there really is some big issue with my weight and height, or if they really somehow feel like I do have a disorder, the way I’m behaving and things. (Jessica R., age 27)

I expect my doctor to raise it if it truly is a current concern. Doctors are never particularly good about preventative medicine, so don’t start bugging me about my weight until it becomes a problem ‘cause you don’t do it with anything else, you know, so I do expect them to raise it with me if it’s relevant, otherwise I don’t need to hear about it. (Madeline, age 44)

A few other participants \( n = 3 \) held slightly different views on the role of doctors with regards to weight management, indicating that doctors should raise weight concerns for preventative measures.

I’m considered overweight based on the BMI so I wouldn’t be angry at him, I know he’s telling me the truth, he’s not sugar coating the truth and I appreciate it.
. . I think it’s his duty to tell me. I mean as a doctor what you want is your patient to be healthy and not be sick and to prevent problems. (Jane, age 27)

Letting me know [about being overweight] in the first place is okay because it’s good to be aware, even if his way of putting his words together didn’t really satisfy me. So it’s good to know, because if I didn’t know, who knows where I would have been right now. (Carol, age 18)

Patients’ Understanding of Doctors’ Constraints

Under the third theme of the Weight and Health in the Medical Room category, entitled Patients’ Understanding of Doctors’ Constraints, 11 participants discussed their awareness or appreciation of the constraints doctors’ face when providing care. For example, eight participants talked about the limited time doctors have allocated for each of their patients.

There’s a whole time factor being a physician . . . I think her main deal is just trying to be efficient about it. I think a more in-depth conversation would probably be more effective, but she’s probably thinking that I just need to deal with this quickly because I have other things to do. (Rose, age 23)

I think because they have such a limited time with each patient they just don’t have the time to get into it . . . to really relate and not just see them as the 60th patient you’ve seen, but that sort of thing requires changes in the whole medical
field because doctors again are overworked and they feel underpaid and they just
don’t have the time. (Clair, age 42)

I understand because obviously GPs are overloaded here and it’s difficult to sit
down with every single patient and make an individualized plan, but at the same
time it’s difficult to actually change, make a lifestyle change. (Jessica W., age 22)

**Meaningless Scripts**

Meaningless Scripts was the fourth category under the first core category of
Weight Weighing on the Doctor-Patient Relationship. Under this fourth category, four
themes emerged: Restricted Dialogue; Overuse of Weight Messages; (No) Exploration of
the Correlation Between Weight and Health; and Perceived Lack of Training Related to
Weight-Management Interventions with Women (see Figure 6). Within this category,
participants talked about how they viewed particular weight-related dialogues as
insignificant or underdeveloped, and how the doctor-patient relationship was affected by
these communications.

![Figure 6](image)

*Figure 6. Themes pertaining to the category Meaningless Scripts*
Restricted Dialogue

Under Restricted Dialogue, the first theme of the Meaningless Scripts category, all but one of the participants ($n = 17$) highlighted how doctors offered unhelpful weight advice or provided no advice at all. Hence, the doctors’ comments about weight were rendered meaningless to them. For example, a number of participants ($n = 11$) discussed “obvious” weight-intervention practices provided by their doctors.

I was just kind of like, “thank you, Captain Obvious, like oh I need to eat better, really? Really?” . . . like this isn’t going to help me . . . it was sort of like she just boiled it down to this girl ate too much, she’s not happy with her weight, like you’re smart right, go deal with it. (Ashley, age 23)

She basically told me I should eat well and exercise. Yeah obviously I know I should eat well and I should exercise, that’s not something that you have to be told by a doctor, you know that that’s something that’s good for you . . . I wish that she’d been able to give me a little bit more guidance I guess . . . this is what doctors have done my whole life and it seems to be when I talk to my friends about it, it’s the same experience that they have. (Jessica W., age 22)

She suggested getting some exercise in but I feel like that’s an obvious response to someone gaining weight . . . I could have thought of that if I could have weighed myself. It was like being told the problem and not [being given] any help to solve it. (Rose, age 23)
Mary and Jessica R., both of whom had been labelled as underweight by their doctors, also talked about their experiences receiving restrictive weight-related advice.

She was giving advice to get my weight up, ’cause I told her I can’t get my weight up, it’s not possible, it just doesn’t happen, so she’s like, “Well have multiple meals, have your three large meals a day and then fill it up with snacks.” I’m like, “I can’t eat that much either, that’s a lot to keep eating!” . . . I mean if there was something that she knew by just being a physician that would have been helpful but there was nothing. It just seemed like a really random suggestion that wasn’t really supported by anything else. (Mary, age 26)

He was just telling me eat more and it’s like, can you give me a bit more information? The way he presented it was just kind of telling me, you should eat more, you might feel more feminine in certain parts of your body if you eat more . . . that didn’t really make sense to me. (Jessica R., age 27)

Several participants (n = 6) including Emily, Jessica, and Les, talked about situations where their doctors indicated that they had a weight problem, and yet no support was provided for how to manage their weight.

The most direct advice I’ve been given is that, “oh your weight is so-and-so, you’re classified as underweight/overweight on the BMI scale” . . . I was just pretty much told you’re too fat, lose weight . . . I just wish that doctors would
have more specific advice other than saying you’re overweight, lose weight.

(Emily, age 37)

He just said you’re overweight. He didn’t tell me anything. He didn’t even give
me some suggestions on how to lose the weight, he didn’t tell me things to cut
out, he didn’t tell me to drink more water, he didn’t tell me anything like that. He
just told me to lose the weight. (Jessica W., age 22)

His advice was that there was a skinny person in me. (Les, age 45)

**Overuse of Weight Messages**

Under the second theme of the Meaningless Scripts category, entitled Overuse of
Weight Messages, just over half of the participants \((n = 10)\) discussed experiences where
they felt that their doctors’ messages were devoid of meaning because they were
repetitive, unelaborate, or used scare tactics. For example, nine participants talked about
hearing the same repetitive message every time.

Nobody’s really interested in looking at any other angle. You’re stuck with diet
and exercise, which dieting does not work . . . it’s always you and the food. It’s
always the same, it’s always the onus is on you . . . everything just seems
unhelpful and negative. (Clair, age 42)
It’s the same response that I have when anybody says anything, it’s been so constant my entire life it’s almost like my mind just checks out because it’s like okay, here we go, somebody else saying something . . . my attitude is, say what you need to say and I’m just going to keep doing what I’m doing . . . I won’t be angry or rude but it’s like, there’s really no point of you saying anything about this. (Mary, age 26)

I have received weight advice many, many times so it’s nothing new to me. I’ve received it since I was a child actually . . . it would be helpful if I got something else to take away with me. (Nine, age 22)

Clair and Sarah also talked specifically about scare tactics they had received and how over time, these became meaningless to them.

His specific advice was try to follow this dietary measure and cut out the cola and the soda and all the things you love, that it would affect your diabetes and you have to think about how it affects your blood sugar levels, your muscles, and your bone structure, and it’s very horrific . . . you could lose your limb, eyesight, which is all you know true in some ways, but not the way they try to tell you. They try and scare you, that’s the scare tactic . . . it has no effect after a while. (Clair, age 42)
My previous doctor, I was seeing her in my 20s, said, “If you don’t do something you’re going to have your first heart attack at 35,” which obviously didn’t happen.
(Sarah, age 45)

(No) Exploration of the Correlation Between Weight and Health

Under the third theme of the Meaningless Scripts category, entitled (No) Exploration of the Correlation Between Weight and Health, 10 participants discussed experiences where the topic of weight management was broached; however, no explanation or correlation between weight and health was provided, and therefore the topic was rendered meaningless.

He didn’t even tell me that this could cause health problems . . . you know about why they’re bringing it up, and what can happen if I continue eating, he never gave any information so it was up to me to go and look it up. (Carol, age 18)

He just carried off right there and instead of exploring it . . . or explaining why the weight is an issue, tying it into how a tumour turns into a problem because you’re big is beyond me . . . but that’s ’cause I’m big. It doesn’t even make any sense not explaining the how, if in fact it ties back to what your issue is. (Les, age 45)

It’s never a case of okay, well regardless we’re worried about your weight being this low for X, Y and Z, medically speaking . . . if they could explain why being thin is a problem, because aside from people running their mouths, I’ve never had
any complications from being thin . . . but when they just make it an assumption, that one-off comment, there’s nothing in my mind that’s separating them from anybody else, it’s all the same thing. The same way I wouldn’t listen to anybody there, I don’t listen to my doctor. (Mary, age 26)

Emily described how she believed patients might be more motivated to lose weight if doctors’ recommendations were tied to a medical explanation.

If doctors can positively link weight management to the management of certain conditions like blood pressure, PCOS, cholesterol, some patients will be more motivated to learn more about nutrition and healthy lifestyles. (Emily, age 37)

Perceived Lack of Knowledge Related to Weight-Management Interventions with Women

Under the fourth theme of the Meaningless Scripts category, entitled Perceived Lack of Knowledge Related to Weight-Management Interventions with Women, all but one participant \( n = 17 \) described instances where they perceived their doctors, male or female, to lack knowledge in providing weight interventions to women.

I just think that she wasn’t well prepared to deal with somebody that isn’t standard. I think that’s a huge problem and I’ve encountered that with most of the GPs I’ve ever seen. It’s just like she didn’t know how to respond to, oh you’re an active person already and you have weight issues, so how can we mitigate
between your needs and what is going on with your body right now. (Blank, age 24)

I think they just follow that lovely little BMI guide, I don’t think they can think beyond that, and that’s what kind of makes me sad; it’s oh well you’re this height and you’re this age, so that’s the thing. I don’t feel like they have a comprehensive knowledge set for what they’re doing. (Mary, age 26)

**Summary of Weight Weighing on the Doctor-Patient Relationship**

Weight Weighing on the Doctor-Patient Relationship was the first of three core categories that emerged from the women interviewed in the present study. Under the core category of Weight Weighing on the Doctor-Patient Relationship, four important categories emerged: Weight and Power in the Doctor-Patient Relationship; Weight in Context; Weight and Health in the Medical Room; and Meaningless Scripts. Throughout these four categories, participants’ experiences uncovered the many ways in which various interactions strengthened or ruptured the doctor-patient relationship and the integral role weight played in shaping this relationship.

The first category within the core category of Weight Weighing on the Doctor-Patient Relationship, entitled Weight and Power in the Doctor-Patient Relationship, included five themes: Unsolicited Advice; Delivery of Weight-Related Dialogues; Expression of Negative Stereotypes Regarding Weight and Bodies; Loss of Voice; and Importance or Trust Placed on Doctors. Beginning with the first theme of Unsolicited Advice, many participants described having experienced various negative emotions,
including shock, disdain, anger, and frustration, as a result of weight-management conversations initiated by their doctors. These conversations predominantly focused on the importance of losing weight; however, for a few of the participants, unsolicited advice focused on the need to gain weight. In each of these circumstances, participants discussed how this gratuitous advice from their doctors negatively impacted the doctor-patient relationship thereafter.

The second theme, Delivery of Weight-Related Dialogues, highlighted similar interactions that negatively impacted the doctor-patient relationship. All participants reported experiences where their doctors delivered weight-related information in a cold, harsh, unprofessional, inappropriate, demeaning, or condescending manner. In turn, such experiences naturally degraded the doctor-patient relationship and further illuminated power differentials between both parties. The relationship was especially affected for those participants who had been a patient of their doctor for several years. Three of the 18 participants talked about having positive experiences related to the delivery of weight-related messages from their doctors. These participants explained how they felt validated and cared for, and were given the space to voice their feelings and needs. Predictably, these participants felt a positive connection with their doctors and felt as though they were being treated like human beings.

The third theme that emerged from the Weight and Power in the Doctor-Patient Relationship category was entitled The Expression of Negative Stereotypes Regarding Weight and Bodies. This theme involved participants’ experiences with their doctors’ communications conveying negative stereotypes about their bodies and weight. Situations whereby participants felt blamed or shamed for their weight had a particularly adverse
impact on the doctor-patient relationship. Participants observed these communications to reveal doctors’ weight stigma regarding overweight individuals, perceiving them as lacking control or willpower. Importantly, a few women did not go back to their doctors by whom they felt shamed. Conversely, the few participants who described experiences where they did not feel shamed for their weight felt as though their health was being treated and not their fat—a factor that played a powerful role in strengthening the doctor-patient connection.

The fourth theme, entitled Loss of Voice, highlighted feelings of dismissal experienced by many participants. Participants interpreted this dismissiveness to be related to the weight or size of their bodies. Similar to the three previous themes, the experience of loss of voice had a negative impact on the doctor-patient relationship, increasing the power differential between doctors and patients, and enhancing an environment of authority and control.

The fifth and final theme that accentuated the power differential experienced within the doctor-patient relationship was Importance or Trust Placed on Doctors. Those participants who placed a high importance on information or advice from their doctors responded to their weight advice more seriously than participants who did not. Alternately, other participants critiqued the “expert role” of doctors, questioning their knowledge and information as a consequence of negative experiences in the past. Overall, the category of Weight and Power in the Doctor-Patient Relationship exemplified the varied ways in which communications about weight influenced the experience of power within the doctor-patient relationship and, in turn, the quality of care received.
The second category of the Weight Weighing on the Doctor-Patient Relationship core category, entitled Weight in Context, encompassed four themes: (No) Exploration or Importance Placed on Social Location; (No) Exploration or Importance Placed on Biological, Medical, or Psychological Histories; (No) Exploration or Importance Placed on Participants’ Individual Lifestyles; and (No) Exploration or Importance Placed on Other Variables Contributing to Presenting Medical Concerns. Across this category, the participants all described the impact that interactions void of exploration had on the doctor-patient relationship.

The first theme of the Weight in Context category, (No) Exploration or Importance Placed on Social Location, encompassed experiences related to a lack of dialogue and consideration for such factors as participants’ SES, ethnicity, and gender. When weight-related advice did not include sensitivity to these important variables, participants described feeling unable to effectively incorporate doctors’ weight-management suggestions into their lifestyles.

In the second theme of (No) Exploration or Importance Placed on Biological, Medical, or Psychological Histories, many women interviewed talked about perceiving their doctors’ interventions as neglectful of important factors that were intertwined with weight-related issues. These included biological, medical, or psychological histories. Across these themes, participants described how neglecting to explore such factors failed to lead to a balanced perspective on participants’ weight and health.

Closely connected to the above themes, the third theme, (No) Exploration or Importance Placed on Participants’ Individual Lifestyles, illuminated experiences in which participants’ doctors did not consider or explore important aspects related to their
unique lifestyles. For instance, the women interviewed discussed how factors such as barriers to their involvement in physical activity, their inability to acquire sufficient sleep or maintain a proper nutritional diet, as well as career and/or academic demands, were often not considered. Accordingly, this left participants feeling as though their doctors had little understanding of the obstacles they faced regarding managing their weight. In these situations, participants felt less able to utilize the weight-related interventions outlined by their doctors.

The final theme of the Weight in Context category, entitled (No) Exploration or Importance Placed on Other Variables Contributing to Presenting Medical Concerns, showcased how participants perceived their doctors’ particular views regarding the root cause of their medical issues. For instance, a number of women discussed how their doctors considered weight as the primary cause for any presenting physical complaint, even when weight was not directly related to their ailment. Furthermore, some women discussed how weight loss or gain was often conceptualized as the only solution for their presenting medical concerns. Consequently, participants felt that their doctors lacked a holistic representation of their health.

The third category within the Weight Weighing on the Doctor-Patient Relationship core category was entitled Weight and Health in the Medical Room and included the following three themes: Assumptions About Health and Weight; Role of Doctors in Weight Management; and Patients’ Understanding of Doctors’ Constraints. Within this category, the women interviewed discussed their perceptions of their doctors’ views on weight-related health, as well as their own expectations of doctor involvement
in weight-management practices. This category also included participants’ understanding of the many barriers faced by doctors in Canada’s current medical system.

The first of these themes was Assumptions About Health and Weight. All of the participants perceived their doctors to hold the assumption that weight was correlated to one’s health. This theme illuminated the tendency within Western culture to “medicalize” obesity, or more specifically, to use weight or body size as a direct indicator of health. For instance, participants described experiences where their weight was problematized in the absence of any troublesome medical results. Many women described negative experiences where they felt judged unduly for ill health purely based on the size of their bodies. Body Mass Index (BMI) was also a topic of discussion with the majority of participants indicating that BMI was used to determine their health status.

Under the second theme entitled Role of Doctors in Weight Management, participants described their views on what they believed the role of a doctor should be within the weight-management realm. Included in this theme were participants’ ideas on when in the medical context the topic of weight should be broached. Several participants preferred to have discussions about weight only if and when there was an evident medical concern related to their weight. A few other participants were open to discussions of controlling their weight as a preventative measure. Participants also shared their awareness of the barriers that doctors faced within the medical system, as reflected by the third theme, Patients’ Understanding of Doctors’ Constraints. For example, many participants talked about the limited time doctors can allocate to their patients.

The fourth and final category under the core category of Weight Weighing on the Doctor-Patient Relationship, Meaningless Scripts, addressed particular types of weight-
related dialogues that were deemed insignificant or unimportant due to the content or practicality of the advice. The themes represented in this category included: Restricted Dialogue; Overuse of Weight Messages; (No) Exploration of the Correlation Between Weight and Health; and Perceived Lack of Training Related to Weight-Management Interventions with Women.

The first theme, Restricted Dialogue, showcased troublesome experiences where participants’ weight was problematized; however, no dialogues on how to manage weight were provided. Closely tied to the above descriptions were experiences related to the second theme, Overuse of Weight Messages. For instance, participants discussed a number of overused messages from their doctors that they stated were meaningless in nature because they were repetitive, unelaborated, or used common scare tactics. These weight-management prescriptions often failed to fit within the participants’ lifestyles or conceptualizations of health, and thus had little impact on one’s motivation to change.

Another important theme under the Meaningless Scripts category, entitled (No) Exploration of the Correlation Between Weight and Health, showcased the importance participants placed on having doctors explore and communicate the correlation between their personal weight and health. This failure often caused participants to minimize their doctors’ weight messages due to a lack of understanding of the medical reasons indicating how and why their weight was deemed a health risk, and further fuelled participants’ frustrations towards weight-related care.

The last theme of the Meaningless Scripts category, entitled Perceived Lack of Training Related to Weight-Management Interventions with Women, exemplified how many participants viewed their doctors as lacking the knowledge and training required to
deliver useful weight-management advice. Across this theme, participants talked about how sensitive the topic of weight was, particularly for women, and how they viewed the lack of such training as a barrier in providing a comfortable environment conducive to discussing the sensitivities related to weight.

As can be seen from the various categories included in the core category of Weight Weighing on the Doctor-Patient Relationship, communications about weight are relevant to expressions of power, expertise, and voice within the doctor-patient relationship. The categories included in this core category elucidate the impact of power and privilege, weight-related stigma, lack of understanding of participants’ lifestyles, as well as health assumptions and scripts that interacted with the doctor-patient relationship. Chapter 4 will highlight the Patients’ Self and Body Experiences, illuminating the everyday life experiences of participants within the context of weight, as well as providing a more focused exploration of how doctor-patient interactions are impacted by weight-related dialogues and care.
CHAPTER FOUR
PATIENTS’ SELF AND BODY EXPERIENCES

“If they are bringing up weight, they should know who their patients are.”
Carol

Chapter 4 examined the second of the three core categories that emerged from the analysis, specifically, Patients’ Self and Body Experiences. Under this core category, three categories emerged: Ongoing Medical, Psychological, and Social Encounters; Weight-Related Experiences in the Everyday; and Patients’ Self and Body Experiences in Relation to the Doctor-Patient Interaction (see Figure 7). Patients’ descriptions of their ongoing self and body experiences helped to clarify and provide understanding for the context of participants’ perceptions and experiences in relation to weight-related dialogues with their doctors.

Figure 7. Categories and themes emerging from second core category Patients’ Self and Body Experiences
Ongoing Medical, Psychological, and Social Encounters

Ongoing Medical, Psychological, and Social Encounters emerged as the first category under the second core category of Patients’ Self and Body Experiences. This category included five themes: Medical Issues; Mental Health Struggles; Weight Stigma and Discrimination; Societal Influences, Ideals, and Norms; and Cultural and Familial Influences (see Figure 8).

Figure 8. Themes pertaining to the category Ongoing Medical, Psychological, and Social Encounters

Medical Issues

Under Medical Issues, the first theme of the Ongoing Medical, Psychological, and Social Encounters category, half of the participants \( n = 8 \) discussed having dealt with, or are currently dealing with medical issues related to weight including, but not limited to, Graves’ disease, high blood pressure, ovarian tumours, polycystic ovary syndrome (PCOS), and Type 2 diabetes.

I take Synthroid, which is a thyroid hormone replacement, every day. The reason this study appealed to me is because back a few years ago, I got diagnosed with
Grave’s Disease and put on this medication that made me gain a ton of weight. I was like, god this is horrible and I was so unhappy. So that was a huge weight struggle because even though I was exercising, eating really well, and doing everything you’re supposed to do, the medication was making it a big struggle. (Christmas Sweater, age 22)

I have polycystic ovarian syndrome, so I went to an endocrinologist to assess the results of the latest test and I had lost quite a significant amount of weight and she gave me the advice that to keep my symptoms under control, essentially without symptoms of polycystic ovarian syndrome, that I should keep my weight to 140 maximum. (Emily, age 37)

Both my parents have high blood pressure and I’ve been overweight for a long time, so [the doctor] said, “Let’s try to control it through exercise and see if you can lower it . . . I really don’t want to put you on the pills because once you start on the pills then pretty much you’re in . . .” and obviously I didn’t, so then she had to start me on the pills. (Sarah, age 45)

Madeline highlighted an interesting point related to the often-uncomfortable nature of visiting a doctor and how this creates an inherent vulnerability for patients.

I think it’s hard enough to go to a doctor because you’re always going when you’re sick right, and there’s always room for judgement somewhere in that, like
you haven’t gotten enough sleep, you haven’t got enough veggies. It would be like going to a psychologist if you’re depressed and have the psychologist go, “you’ve been depressed for a long time, you should fix that,” you know you’ve always got a vulnerable population coming in, in a way. (Madeline, age 44)

Mental Health Struggles

Under the second theme of the Ongoing Medical, Psychological, and Social Encounters category, entitled Mental Health Struggles, seven participants talked about mental health issues that interacted with their weight, including anxiety, depression, and disordered eating.

I had mental health stuff like anxiety and depression, which manifested itself in a major weight gain. It’s so interconnected. I’m sitting here and a lot of people now would have no idea because I look normal right, but I was a big girl. It was gross. I was really thin when I was 18/19, around 120 pounds, and I won’t get into the whole thing but I have post-traumatic stress and so I was put on a medicine to help regulate flashbacks. I was upset and I would just eat and then I stepped on the scale and I was like shit, I’m like almost 190 pounds. (Ashley, age 23)

Anxiety definitely has been a big part of it . . . when I was younger I sort of had eating disorder issues and that kind of thinking might have led up to eventual anxiety . . . I was conditioned a certain way . . . and I had this extreme anxiety about it so that totally influences how I see everything. (Blank, age 24)
I told him a while back I was depressed so [the doctor] put me on these antidepressants to maintain my mood so that I’m not down or I’m not too up, so he said, “How do you feel?” and I said, “I’m feeling okay but I don’t work out as much as I used to.” I mean I used to be a gym person but now it’s like I just slouch back and stuff because of my mood . . . well he says, you know what it is? It’s the meds, too. The meds put on a bit of weight. (Juliette, age 40)

**Weight Stigma and Discrimination**

Under the third theme of the Ongoing Medical, Psychological, and Social Encounters category, entitled Weight Stigma and Discrimination, half of the participants (n = 9) talked about experiencing different forms of weight stigma and/or discrimination in the general community, capturing the wide-ranging, judgmental perceptions and assumptions that are prevalent in modern Western culture. This theme showcased the impact of such stigma on participants’ self and body experiences.

I found that when I was heavy I wasn’t getting a lot of jobs . . . I remember being really surprised when applying for this camp that everybody got accepted to and they said, “we’re not really interested, we don’t really have a spot for you, Ashley.” And I was like, what the fuck, people with a lobotomy get into this place – felt like they didn’t want the fat chick there. (Ashley, age 23)
I used to have this friend who was disgusted by people who were obese and I was just like, oh my god are you for real? You people have no idea, you just have no idea. How about you just be grateful you are the size that you are because you know what? Maybe it is because I go to McDonald’s every day, maybe that is the reason, or maybe it’s because I have such a low self-esteem. Like you don’t know why! People are so damn judgemental ’cause you know the skinny folks have all the answers. (Les, age 45)

I have the most bizarre stories. I was in the elevator and this lady kept staring at me and she’s like, “I hate thin people like you, all of you are so disgusting and honestly I wish you would all just kill yourselves.” And at that age [16 years old] I didn’t say anything and then I started crying when I got home. I’ve always had weird experiences like that where people just feel they can take it upon themselves to let you know that you’re unattractive for this reason. (Mary, age 26)

Furthermore, Ashley and Les specifically discussed instances where they felt they were defined as being “less smart” due to their body size and weight, illuminating once again the many weight stigmas that exist in today’s society.

I remember being partnered with somebody in a sociology project and it was some asshole football player, and he said to his friend, “That bitch probably eats more hamburgers than she writes essays!” And the truth is, I was a good student, I did very well in school, and I remember thinking I would have worked with you
and we probably would have done well, and it was like, why do you need to judge me? (Ashley, age 23)

I know the stigma. I took a nutrition course and the lady giving the course was a doctor who dealt with nutrition, and even her attitude toward obesity was very clear. Not a very good one. And my friends laughed at me ’cause I went, “I think it’s cause I’m fat. . . .” That nutrition teacher was pretty blatant with her attitude, it’s the comments that she would make and how she treated a couple of us who were bigger versus the ones who were not . . . you know yet hey, I’m an A+ student! (Les, age 45)

**Societal Influences, Ideals, and Norms**

Under Societal Influences, Ideals, and Norms, the fourth theme of the Ongoing Medical, Psychological, and Social Encounters category, all 18 participants described their views on Western society’s prescribed body weight and beauty ideals for women. Specifically, participants highlighted issues related to gender and weight, perceptions of societal norms regarding what constitutes a healthy body size, the unrealistic thin ideal and more recent movement toward acceptance of larger bodies, as well as protective factors shielding women from internalizing dominant societal norms related to weight and shape. For instance, 7 participants talked about their experiences and perceptions regarding gender and weight in Western society.
Society has a clear-cut perception of what you should look like as a female because you know what? As sad as it is, this is a gender issue . . . because our society says you have to be skinny, because that’s socially acceptable . . . that is just society’s perception of what someone perfect should be . . . someone who’s skinny and who’s drop dead gorgeous. (Les, age 45)

Going back to the female stereotyping of what an attractive woman should be, like society keeps on hammering images at you and they’re like, women should be thin, don’t eat anything. . . . I realize that you have to be slim to be attractive, like that is something that people are telling me and throughout a good chunk of my life I definitely believed that, and now I’m just going back and forth between I need to be really on top of this more, you know fit that ideal, and meanwhile I have other important things to do, I can’t think about this now. Kind of like a seesaw. (Rose, age 23)

Several of the participants (n = 6) discussed their interpretations of what society portrays as a healthy body size, illuminating predominant views regarding the medicalization of obesity and how this has affected their experiences living in Western society.

I think most people are sold the image of health. You have to look like the woman on the cover of shape health and you have to do all these sports, and then have a nutritionist design your regiment of protein shakes and supplements, and all that
and meditate and yoga, and I just find it extremely unrealistic now. When I was younger I thought, this is what you had to do, and there’s no way I can do that so why bother right? (Emily, age 37)

I feel like the media always portrays that beauty is associated with like being thin, but health too. A lot of the time when you see commercials for running shoes and workout clothes and healthy things, they don’t show the skinniest people but they do show slim people. They always have good complexion, their hair always looks shiny, they have their outward image of health in the media for sure. You never see a commercial for a healthy product like Special K and it’s an overweight person ever, so not just in the media, but like in your everyday life. (Christmas Sweater, age 22)

Closely tied to the influence of gender and weight, as well as participants’ perception of societal views on what constitutes a healthy body size, many participants’ 

(n = 11) discussions also surrounded what they believed to be an unrealistic “thin ideal” of women’s appearance that is widely recognizable in today’s media and society as a whole.

I think society places a good deal on weight, and in the media, even though it’s not all accurate, there’s tons of Photoshop involved and such, but the end product is the ideal product so I feel like they reinforced the mantra that thin is better . . . I find it’s extreme. (Joyce, age 18)
I feel like society’s idea of health is not real, it’s something dead on the centre of a spectrum that no one can really attain, and then it’s not even having a certain weight, it’s having a certain distribution of that weight. You could be exactly what you’re supposed to be medically, but if it’s mainly on your arms or whatever, well you’re fat, or you’re still too thin, or whatever it may be, so it’s not real. (Mary, age 26)

With the whole media thing, with Miley Cyrus, Kim Kardashian, and Beyoncé, and I’m not saying she doesn’t have a nice ass because she does, but she has a dietician, a personal trainer, the money, the organic food, you know she probably drinks organic soy goat’s milk. They can have that body because they have that lifestyle, that money. They don’t cook. It’s still all in the media and music that you’re supposed to look a certain way, thin. (Clair, age 42)

Some of the participants \( (n = 4) \) talked about a movement they saw in the media toward the acceptance of different shapes and sizes, but that there remained a contradiction within society, given that the messages and images related to the thin ideal were still so prominent.

It’s very skewed. I mean you have on TV or when you watch a fashion show people are literally size zero and it’s like, I definitely know I’m not that. So I think it does make girls feel really bad that they’re not a size zero or size two, but then you know more and more they have plus-size models that are trying to like...
say, “hey, here’s the other side of it.” I think we are more open because there’re more plus-size models and stuff like that. Even actresses are coming out and saying, “hey, this is me!” (Sarah, age 45)

I think that obviously there is a huge leaning toward really, really thin, especially for women, and it’s like, oh you’re only healthy if you’re a size two or under, which is obviously not the case at all, and I realize that, but I find that there is a little bit more of a movement toward body realism in the media more recently. I don’t know whether it’s the Internet or whether it’s just more women are getting fed up and saying like, “I don’t look like that!” I don’t know very many people who do. Obviously there are women who are very thin, but even those women feel like, oh my boobs or my butt’s not big enough, or I’m not muscular or toned enough. There’s always this push to be different than you are, but I do feel a little bit more recently there has been a little bit more of like, you can be a size eight and you’re still a woman and you’re not just this fat cow. (Jessica W., age 22)

Society is always saying, oh you should be like this and you should be like that, and you know it’s hard. I see a lot of girls that kind of starve themselves and stuff, which is not healthy, but I think society is becoming more accepting of the fuller woman, you know, which is good. (Juliette, age 40)
Several of the participants \((n = 4)\) described protective factors that safeguarded them from internalizing societal messages regarding beauty ideals, or helped them place less importance on attaining these ideals.

When I was younger, I suffered a lot on account of this societal focus. With age I learned to critically detach myself from these ideals. Now I would say that it’s a nice filter for me to use to weed out people and influences I don’t want in my life. I wouldn’t say it currently affects my health in a negative way. (Blank, age 24)

They get you in your 20s and now nothing in the media is going to affect me anymore because I don’t have to care about that . . . all these things [referring to media images of beauty] are supposed to have some sort of social goal that you’re going to settle down or get married, and I’ve been through all that and I didn’t need to be a certain weight to achieve that . . . again, the older you get the more evolved you get. Do you care about 10 pounds? Do you care about receding hairlines? No, what you care about is the person that you’re with is going to care about you. (Clair, age 42)

For me personally, it’s been pretty moderate. I’m generally big-boned and fuller, but I don’t find I’m excessive or anything so it’s just balancing it out, you always want to be thinner than what you are, right, never over, and I know I’m over but that’s okay . . . I’ve always been an average girl but everybody has their body weight and I think mine is fully proportioned. (Juliette, age 40)
Jessica W. talked about how having a support network of women to share ideas about weight and weight management was helpful for her.

Having a support network, I find, is really helpful, and talking to other women about how they feel about their weight and exercise and food, it’s really enlightening ’cause I feel like a lot of times women feel like they’re the only ones who are struggling to find something that works for them but not at all. Pretty much everybody is struggling with some sort of body image issue. (Jessica W., age 22)

Alternately, Clair discussed her experiences of how women joining forces can be detrimental to one’s resiliency against internalizing societal norms.

We’re our own worst enemies, we starve ourselves to impress or we go to the excess to impress, who? If you could just get women to stop, this is where men actually excel because they’re not driven by the media and the Internet. They don’t care on some levels . . . they don’t fall for everything that we do and it’s so annoying when you talk to other women. This is where we’re not really helping each other. (Clair, age 42)

Cultural and Familial Influences

Under the fifth theme of the Ongoing Medical, Psychological, and Social Encounters category, entitled Cultural and Familial Influences, 14 participants
highlighted how cultural or familial traditions relating to food and diet influenced their behaviours as children and/or evolved into current behaviours in adulthood. For example, three of the women interviewed described how their parents’ location of origin impacted their food choices growing up.

Mary discussed her parent’s transition from Sri Lanka to Canada and the struggles that arose surrounding their food choice as children.

My family grew up back in Sri Lanka so food choices were completely different, like for instance, a lot of the extremely ethnic foods are super healthy foods, loaded in nutrients, but then they were trying to cook it for young kids that are growing up in Canada. We don’t want it, so they were trying to figure out what these Canadian foods are that we can give our kids, but they don’t have that kind of knowledge, so a lot of the times they just grabbed things that we kids would like, but as children you want the most terrible things. We ate a lot of junk foods since we were really small, like nothing was really regulated either, so if we wanted pop we could have pop, whenever we wanted. (Mary, age 26)

Sarah and Emily described the influence of having parents who lived through war in pre-revolutionary China, and how this affected their parents’ relationship with food after transitioning to Canada.
My parents are both grew up in Hong Kong, and when they were young it was during the war, so they know what it’s like to be without food and now they kind of overcompensate. So all my life they’d buy things in bulk, they’d store up on things partly because of this mentality of you never know when you’re going to be without, and also being poor they would get stuff that’s on discount, but then discount stuff may not be really healthy stuff . . . things like McDonald’s my dad would always be like, well you got to get the biggest size cup of drink and the largest size fry because that’s how you get your money’s worth. So even as an adult when I go get my own food, no matter what kind of fast food it would be, I would always get the combo whether I needed it or didn’t. (Sarah, age 45)

My father grew up in pre-revolutionary China, and for most of his life when he was young there wasn’t a lot of food around. You see this pattern with a lot of immigrant families as well with parents who grew up there, there was a shortage of food and now they’re in Canada there is no shortage of food. There is food thrown at you everywhere pretty much, and food is an easy way to show your love and to give your children a treat, so I was a little bit chubby as a kid, and my parents pointed it out but it didn’t really stop them . . . and they always say, eat, eat, eat. So it’s just an interesting juxtaposition. (Emily, age 37)

Several participants (n = 7) talked about how cultural transitions related to food carried into their present-day lives, and how this impacted their weight or weight-management interventions. For instance, Chrystal, from a Latino background, Juliette,
from a Greek background, and Clair, from a Portuguese background, discussed similarities regarding their present-day experiences of culture and food.

My mom, she started cooking a lot, and I loved her cooking, but guess what? Too much. The food was awesome from back home, from tamales to all kinds of foods and everything . . . she would stuff me. It was like, you better eat all your food because you’re very lucky and fortunate to have all this food, and I’d have a huge plate and I’m like, oh my god, Mom, no . . . so like depending on your background and where you come from it’s like dali, dali, dali, eat more, more, more, no you hungry, here keep eating. That’s how you get really bad habits, and I was at home like I would be passing the kitchen and I’d grab a cookie. (Chrystal, age 37)

I grew up in a traditional Greek family and we ate a lot of home-cooked meals, more traditional stuff like how they did it back in their country—not like McDonald’s or anything like that . . . and if you have ever seen the movie called My Big Fat Greek Wedding? You know we like to do things large, you know the lamb on the spit, and we like everything in large amounts. (Juliette, age 40)

I mean, there are people in my family that are probably 500 pounds because everything we cook, lard, cream, soy what? Because in the Portuguese culture they don’t throw things away, they don’t throw away the skin or cut away the fat, you cook everything . . . I was raised to not waste food and you know you eat
everything that was put in front of you, so for me that’s my outlook on food.

(Clair, age 42)

Similar to the above participants’ experiences, three of the women interviewed, including Jane and Sarah, discussed how coming from a Chinese cultural background interacted with their current eating routine and weight-loss goals.

Sometimes cultural foods, you’re stuck, like carbs. From my culture, rice is one of the biggest foods, and noodles, dumplings with the carb-y skin, it’s all carbs so that was big ’cause lowering that intake was very hard. I mean, I think the reason why I’m not too successful is because of the cultural thing. It’s hard to get around that although you know you have to kind of motivate yourself and really limit how you can adhere to the cultural food and then try to keep clean from that.

(Jane, age 27)

In Chinese culture, the food is so central, it’s the way to celebrate, so if you like to treat someone well, the gifts are always about food . . . they’ll shove food in your face and then it’s really rude on my part if I don’t eat, that’s just how like, culture is . . . and even the way we eat food. In Asian culture, we’re all sharing those dishes, so you’re worried about portion control but you don’t know what you’re eating ’cause you’re just grabbing in the middle. You probably could eat three times what you normally do. . . . I would say if you’re trying to lose weight, or if you’re trying to be cautious, it’s a bad thing. (Sarah, age 45)
Several other participants \((n = 4)\), including Joyce, Nine, and Jessica W., described different family dynamics that played a part in their upbringing and current views on weight-related beliefs and practices.

I was adopted and she [mother] was from a very Caucasian family, so the weights are very different. Her whole family is a very different build than me, so I remember becoming more conscious of that when I grew older. I felt that was really awkward. She adopted me at 47 so her whole family is older, and when you get older you’re also a lot more weight focused, so that was always a big thing. I also think it’s different in religion, too, ’cause I grew up in a very Christian community and food was a pretty big part, like you had Communion and Passover and all of that, and at least where I grew up, you wanted to look good but there was the whole “don’t be gluttonous” thing, so I think religion also has its own separate thing. (Joyce, age 18)

We had a lot of fish at home, but at the same time we had a lot of pop. What I’ve noticed, though, is that over the years, now when I have my own money, I’ve started bringing the junk food, whereas when I was a child, it was more controlled by them, more like you can’t have that. But now I’m an adult, I make my own decisions and I go out a lot more, so that’s hard ’cause there’s nothing healthy outside. (Nine, age 22)
My mom was a dancer and she’d struggled with anorexia before . . . but she [mother] would give me really high-calorie things all day long and then she’d be like, “Oh you’re so overweight,” or “Oh if you’re still overweight when you get to be 18 I’ll get you gastric-bypass surgery.” As I grew older I sort of rebelled against that and I was like, okay, I don’t have to eat how you’re eating and you’re obviously sick and I don’t want to be sick. So I sort of went to the other end of the spectrum, whereas she was sick but then I was also sick, like I was overeating and she was under eating sort of a thing. (Jessica W., age 22)

Christmas Sweater talked about how her family upbringing had a positive influence on her with regards to her views on food and exercise.

We are all big into exercise and we eat crappy food sometimes, but for the most part we eat pretty healthily . . . I saw the way it helped my mom to exercise and she had her challenges, too, but it would be fun to exercise and you would feel good if you ate well and if you prepared your own food. I saw that made her happy and I thought, okay, I think I’ll do that. (Christmas Sweater, age 22)

**Weight-Related Experiences in the Everyday**

Weight-Related Experiences in the Everyday was the second category within the second core category of Patients’ Self and Body Experiences. Under this second category, three themes emerged: Weight-Related Activities, Struggles, Barriers, and Consequences; Self-Objectification; and Body Surveillance (see Figure 9). This category
included participants’ behaviours and challenges connected with weight, as well as how their body perceptions influenced their experiences living in the everyday.

**Figure 9.** Themes pertaining to the category Weight-Related Experiences in the Everyday

**Weight-Related Activities, Struggles, Barriers, and Consequences**

Under the first theme of the Weight-Related Experiences in the Everyday category, all 18 of the women interviewed discussed experiences related to weight battles, obstacles, and/or consequences. For instance, over half of the participants ($n = 10$) talked about struggling with weight for most of their lives.

I would say that for most of my life I probably qualified as overweight . . . I think it was the cumulative effect of being told that I weighed too much all my life, even with a current BMI of 19, I am conditioned to expect to be told that I weigh too much. (Emily, age 37)

I would say probably even from mid-teens to now it’s always been like this. I’ve always been overweight and not particularly tall so, yeah, it did look terrible . . . it’s just not so easy . . . food always was a reward but also a comfort . . . it’s
always around me. If I’m upset about something, I’ll go to the food; if I’m happy
’cause I did something well in my life, I’ll go to the food to celebrate, so yeah, it’s
like this crazy thing that I do. (Sarah, age 45)

Mary discussed her experiences being considered underweight for most of her life
and the struggles that accompanied that particular weight status.

I’ve gotten used to it because even outside of the medical environment, I guess
my weight always surprises people ’cause my frame is really tiny so people are
always like, oh my god, you’re so small . . . so I’ve always had to deal with it,
especially when I was younger. It used to be really confusing for me. So I kept
thinking okay, I must be so incredibly ugly if everybody is telling me this,
strangers, like no matter where I go . . . I didn’t naturally have some kind of
insecurity where I had low self-esteem or anything, but just that particular item,
like if somebody said that about my weight . . . it just made me uncomfortable.
(Mary, age 26)

All 18 of the participants described a number of different activities that they have
tried, or that they currently do, to help manage their weight.

I’m a bit rigid now. I’ll have little snacks, but I mean I’m not going to go and
have tons of fries or chips or anything . . . I don’t eat desserts ’cause I’m terrified
of gaining weight. Like I’ll have pizza or Starbucks but I don’t have really
anything other than that, I don’t want to be fat, I don’t want to go back to that. It’s almost like it’s a cycle. (Ashley, age 23)

I started running in the mornings so that kicked off for about a month and a half or so, and I definitely tried to be more aware of what I ate. I remember I downloaded an app and it’s called Calorie Counter, and it counts your calories for the day and if you want to eat a set amount it will tell you like, hey you’re at your limit. And again I did this for another month and a half. It was more like I should be keeping up with this. (Rose, age 23)

I have lost large amounts of weight before but it usually comes back, as it usually does. All the long-term studies say about 95% of dieters regain all of it in five years but it’s given me motivation to keep doing what I’m doing . . . right now I do a lot of physical activity and I’m super careful about what I eat . . . I do 30 minutes of cardio six times a week. I walk over 60 kilometres a week. I do weight training three times a week. I don’t like doing it but if it’s practical and I can fit it in, I do it . . . it’s just all about balancing. (Emily, age 37)

Furthermore, many of the participants \((n = 13)\) talked about their experiences of dieting and how this weight-loss strategy did not work for them.

I know with Bernstein I lost a significant amount of weight in six months. I was eating 800 calories a day, well who can maintain that? The maintenance piece is
just terrible so then I gained all that weight back . . . I mean weight loss is a billion, billion-dollar industry that promises you all these things, but what they don’t give you is the most basic thing and that is the knowledge and the education to understand the problem. (Les, age 45)

I feel like I was the type of person to be like, oh I’ll start a diet and now I’ll be extreme, very extreme to the effect where I don’t want to eat anything, nothing in moderation. And then that would fail and it would go the other way, so it was a lot of up and down, up and down. (Christmas Sweater, age 22)

I’m always aware of that fact that there is a prevalence of me getting overweight, but then at the same time I don’t really value it as much because I gained back all the weight after that summer. That summer it was a lot . . . I lost some weight but I wasn’t comfortable not eating what I wanted to eat . . . now I just live. (Carol, age 18)

Joyce talked about her experience being diagnosed with an eating disorder and the weight-related activities in which she partook.

The first incident was purging, I never really started purging with the point of losing weight . . . but then I ended up liking the feeling and I lost quite a bit of weight. In grade 11 I met another girl and she had had an eating disorder. She said that if I didn’t want to worry about food I should count calories, she told me
where to get an app, so that’s kind of how things were fuelled and it escalated very quickly after that. I lost 35 pounds in like two and a half months . . . I thought I was being very healthy and then I think I did exercise on top of that . . . I kind of like grew addicted to the feeling of losing weight. (Joyce, age 18)

**Self-Objectification**

Under the second theme of the Weight-Related Experiences in the Everyday category, entitled Self-Objectification, all 18 of the participants described experiences that were related to using appearance as a means of self-evaluation, also known as self-objectification. For instance, most of the participants (n = 15) described instances of feeling as though their bodies were imperfect objects in need of repair.

Well it is hard because I still see this therapist and I was saying things like, “I don’t want to be fat . . . I was wasting so much time ’cause I was fat.” And she’s like, “Okay, you gained weight because you were psychologically traumatized, you need to look at that, not the number on the scale, I get the fact that you lost it but it’s the notion that fat equals bad and thin equals good that’s a problem.” (Ashley, age 23)

It would make me really sad because everybody is always telling me to gain weight, and with me I kept trying to put on weight because I kept thinking if I could just gain five, ten pounds, then maybe people will stop bothering me, I would look more normal. (Mary, age 26)
Furthermore, most of the participants (n = 15) felt some sort of body consciousness or body dissatisfaction.

I’m not the most confident, I have to admit, because the Freshman 15, you know, it was so many years ago and it’s still lingering. I don’t feel good. I know this is the current situation and I think it takes a lot to alleviate it. I have to do something about it. (Jane, age 27)

Well you hear about Britney Spears, like the trends were out and they were saying what a fatty she’s looking like, and I’m thinking holy god, if only I was that fat. Oh yeah, what a big person you know. (Les, age 45)

**Body Surveillance**

Under the third and final theme of the category of Weight-Related Experiences in the Everyday, half of participants (n = 8) talked about the body surveillance they experienced either by others, or internally prescribed by themselves. Within all the experiences of Body Surveillance reported, shame of their bodies was an underlying flavour.

Every time I opened the fridge my mom would almost have a sixth sense and she’d come barrelling down the stairs being like, “That is a carb, why are you eating that?” So all of a sudden I’m a spectacle every time I open and eat right. I used to say to her, “Mom, fat people get hungry, too, like you do understand
that?” You feel like you lose your rights. If I so much as opened a cupboard I pretty much had to write a dissertation about what I was eating. (Ashley, age 23) Well for the obesity part . . . it was quite shameful, quite embarrassing, so I don’t go around telling people that like, oh I’ve been, you know I’m on the obese range or whatever, but I mean all my life people have made fun of me or they’ve tried to give good advice like, oh why don’t you try this. You know I mean, I know what I look when I look in the mirror, it’s not a good feeling. (Sarah, age 45).

In the summertime I get really uncomfortable, like days when it’s 40-degree weather I’m like, well I want to go out in shorts and a tank top, but as soon as somebody sees more of me they’re going to be like, “Oh my god, you’re so small,” versus if I’m wearing sweaters or things, so a lot of the time that becomes a stressor. If I wear strapless dresses, I’m like I should wear something over this, but it’s so hot outside and then I’ll still do it and I feel like I’m going to pass out. (Mary, age 26)

Patients’ Self and Body Experiences in Relation to the Doctor-Patient Interaction

Patients’ Self and Body Experiences in Relation to the Doctor-Patient Interaction was the third and final category, under the second core category of Patients’ Self and Body Experiences. Six themes emerged including: Emotional Reactions; Behavioural Reactions; Contesting Responses; Invalidating and Dehumanizing Experiences; Reactions to the “Fat” Label; and Body Esteem (see Figure 10). Within this category,
participants described important circumstantial reactions they experienced during or after their visit with their doctors that contained weight-related dialogues.

Figure 10. Themes pertaining to the category Patients’ Self and Body Experiences in Relation to the Doctor-Patient Interaction

Emotional Reactions

Under the first theme of the Patients’ Self and Body Experiences in Relation to the Doctor-Patient Interaction category, entitled Emotional Reactions, participants described how doctors’ interactions affected or activated them on an emotional level. The women interviewed in the study exhibited a multitude of emotional experiences. For instance, over half of the participants ($n = 11$) talked about feeling horrible, terrible, or awful during their medical appointment where weight was addressed.

I would be walking down the street crying, so that was really terrible. I could not control it . . . feeling like I’ve not been treated well and that’s not okay, it felt terrible and it didn’t wear off after leaving the office. You feel like you’ve been kicked around . . . I felt terrible. (Christmas Sweater, age 22)
I felt awful, like you didn’t even care to figure out why this happened or anything, or just the fact that like a female is fat therefore it is her fault, right, like she’s responsible for fixing it as an adult . . . I felt like a specimen. Yeah I just felt like I regressed. (Ashley, age 23)

Several of the participants \((n = 6)\) talked about feeling angry during or after their visit with their doctors where the issue of weight was raised.

I just remember it made my body less comfortable to live in for a while. I felt more self-conscious, I felt angry toward him and it really shifted the dynamic between the two of us because before that, I felt like I could talk to him ’cause I felt like he really listened. I felt robbed, I was like, oh you’re kidding me, it’s like basically you’ve done something that I can’t get beyond. It’s like cheating in a relationship . . . it felt like a betrayal. (Madeline, age 44)

Well I mean clearly when I told him that he should grow some hair it was, I reacted to what he said . . . and it still upsets me . . . I have bitter feelings, you know and apparently I’m still angry about it . . . it’s kind of sad actually, now that you say it out loud and you’re talking about it. (Les, age 45)

Many of the participants \((n = 8)\) described the frustration and irritation they felt regardless of the weight-related interaction they experienced via their doctors.
I was frustrated and I felt like I was being judged unfairly... there was no acknowledgment of her lack of preparedness... So that’s the ongoing frustration, and that’s never been solved really... it’s frustration and just feeling like, okay, where am I supposed to find an answer now?... I definitely felt like we didn’t understand each other, like I was wasting my time. (Blank, age 22)

It’s frustrating because it felt like he was a lot more concerned about something I didn’t care about than what I had originally shown up for... I felt he wasn’t concerned about what I wanted... it felt like I came there for nothing... it was just uncomfortable and frustrating. (Jessica R., age 27)

Some of the participants (n = 5) talked about feeling embarrassed and ashamed during or after their visit with their doctors.

My main response was feeling embarrassed and a little ashamed. Prior to that visit, I felt that I was at a good body weight so it was just unexpected... you know, maybe I gained a little weight but not enough for the doctor to be commenting on it... I felt embarrassed about it. (Rose, age 23)

It’s like handle with care, your body is a soft spot for everybody and it wasn’t handled with care, so I stopped going to him. I felt ashamed, like you’ve been overweight for a while, like you’ve been failing for a while, like you’ve let this go on for a while, like it really felt shaming, I was embarrassed. I knew that I didn’t
want to do any more physically exposing kind of medical interventions at that point, like there was no way he was doing another Pap smear on me. (Madeline, age 44)

Four of the participants, including Carol, felt shocked or surprised; seven of the participants, including Sarah, felt judged; and seven of the participants, including Nine, felt concerned.

He just told me I’m overweight, and I was just shocked and appalled . . . I was feeling weird because that never happened . . . I don’t know, I was just shocked, I wasn’t really comfortable with him then because of how he openly said such a thing. (Carol, age 18)

I know it’s probably my personal perception but I was just thinking man, I feel like I’m being judged – even though she was very professional about it, it was very matter-of-fact. (Sarah, age 37)

I think it took me aback, about how serious this was and how far my weight was a problem that I didn’t realize. It was a wake-up call. I was just concerned and I was like, okay, I need to get this under control . . . it did not feel very good. I felt self-conscious and I just felt a little sad. (Nine, age 22)
Two of the participants talked about the positive experiences they had with particular doctors, highlighting how they felt comfortable and understood.

I’ve always been okay going in and talking to her, it made me comfortable . . . I felt as though she had a holistic picture of my health. (Madeline, age 44)

I was more comfortable with my current GP. I’m very comfortable with him . . . everything is addressed with extreme sensitivity, which it’s nice when you come from one extreme to the other, you feel like you actually have a voice and that somebody cares, somebody is taking care of you. (Christmas Sweater, age 22)

**Behavioural Reactions**

Under the second theme of the Patients’ Self and Body Experiences in Relation to the Doctor-Patient Interaction category, entitled Behavioural Reactions, participants talked about subsequent behavioural responses that were influenced by their doctors’ weight-related advice. For example, only three participants talked about being motivated to participate in the doctor’s weight-management interventions. Motivational timeframes varied for these three participants. Namely, Carol felt motivated for one summer, and Chrystal and Jane’s motivation was instilled more long-term.

Because I really place high emphasis on what doctors tell me, at least then I did, I said, okay, this summer I’m going to try and do all I can to heed his advice and lose some weight . . . I did everything I could to lose some weight. I cut out junk,
I exercised every morning with my mom, I ran, I ate vegetables, I cut out sodas. I did everything. And I lost weight for a while, but then I wasn’t comfortable because I wasn’t eating all of the things I loved. So I stopped. (Carol, age 18)

I had bad eating habits . . . like really bad habits, like if I was at home passing the kitchen, I’d grab a cookie; if I’m bored, I eat something . . . then I realized, okay, you know what, what am I doing? I’m at home, I’m consuming a lot of calories. If this was brought to my attention before, I wouldn’t be eating this much. It made a big difference . . . I started walking a lot more . . . it made a significant difference. (Chrystal, age 37)

Eventually it did motivate me. Again he’s not specific so I had to really dig myself, do research, look into books, hear things to find out oh okay, there’s apparently a number of research studies out there, or other doctors came out with methods of fixing the weight problem so yeah . . . you know I had to kind of go through a self-help level to find out for myself because he didn’t tell me anything. (Jane, age 27)

Several participants \((n = 6)\) talked about being actively motivated immediately after the doctor’s visit, but that this motivation wore off after time.

I started watching what I ate. It’s not going so successfully now because I’m not consistent but I remember I did make changes initially. Once it wears off you
forget, go back to your old eating habits, but I remember the few weeks after the visit I watched what I ate. I did not have any pop and I love pop. (Nine, age 22)

After that I really thought about it, I was like, I should try to make a change but long-term honestly, it didn’t really make that big of a difference . . . but to be honest, it didn’t really do that much in terms of exercise . . . and it didn’t honestly have a huge impact on the food just because again, at the time like, I didn’t have the money . . . it’s difficult. (Jessica W., age 22)

Half of the participants ($n = 9$) described how the weight-related interventions with their doctors had no impact on affecting change.

Even though I was like, I can’t believe I’m obese, it wasn’t enough to motivate me to do more about it, right, I wish it did. (Sarah, age 45)

Well, just being told you have to change your ways, like you can’t eat this way and you can’t expect the results that you have experienced in the past, that’s not encouraging. I didn’t find that encouraging so it just makes you not want to try at all. I didn’t. That was not helpful. (Christmas Sweater, age 22)

The one time where she was making sense was to keep the diary; the problem with that is she didn’t follow up . . . that would have probably been more of a motivation for me to do it, but then just to give me this random advice of keeping
a food diary but for what purpose? Are you going to look at it with me, what am I going to do with it? So it wasn’t motivating, like no it didn’t work. (Mary, age 26)

Five of the participants talked about how their visit evoked negative behavioural reactions in the form of doing the opposite of what their doctors had prescribed.

So when I went to the doctor I didn’t bring it up ’cause I never do, but they’re never happy; it’s like you’ve already lost some weight on your own, now you’re going to say, well you got to do more and try harder, and you know it’s like bite me, I’m going to go have pizza . . . I actually did go out for a cheeseburger or a pizza or something. (Clair, age 42)

I thought you [the doctor] must really have issues with weight, and I left his office and I went straight to McDonald’s and had a Big Mac. I shouldn’t have let it but it completely undid all the work I’d done and I just regained all that weight again. It was so deflating . . . I just felt kind of invalidated across the board. (Madeline, age 44)

Both Mary and Jessica R., who were identified as underweight by their doctors, discussed how their visits encouraged what they deemed as unhealthy ways of behaving regarding food and exercise.
It ended up affecting a lot of things like diet, exercise, how I interacted with people and kind of spread to everything. It sounds really silly, but if I wanted to have a salad I’m like no, I shouldn’t, because there’s not enough calories in a salad, I’ll probably burn off most of it. . . . I love doing cardio, too, I find it really a nice stress reliever, but then my doctor was like, don’t do cardio . . . so then it just instilled some kind of fear so I just don’t exercise and then I worry this is probably not the smartest solution, I’m probably really damaging my health, but I’m just really scared. (Mary, age 26)

I remember I had a long walk right after and I guess maybe like psychologically I felt almost a bit like, oh is this too much to walk or something, I guess I did question a little like, am I eating enough, but then I went to a group right after and they were serving pizza and chicken wings so I just ate a lot . . . before sometimes I’d feel bad if I ate a lot of fatty foods and stuff. Now I might be a little bit less caring about that kind of thing but I don’t necessarily think that’s a good thing, it’s almost like I don’t care as much about my health in a way. Like the accumulation of people telling me I’m skinny plus this from a doctor, like I can’t help but take that a bit more seriously. (Jessica R., age 27)

Importantly, five participants talked about not returning to their doctors after experiences in which the topic of weight was broached.
I felt as though what that did is it severed our relationship. It went from me feeling comfortable and looking forward to seeing him to feeling shamed and uncomfortable going in to see him, and again because I haven’t lost that weight . . . I was like, I’m done, I’m just not comfortable, and our relationship shifted . . . it felt like a betrayal and it’s like, oh man, we had a good thing going here and you just wrecked it, and so then I’m like, I’ve got to find a new doctor, and that’s how I came to my current family doctor. (Madeline, age 44)

Well I mean clearly when I told him that he should grow some hair it was, I reacted to what he said . . . it still upsets me. I didn’t go back. (Les, age 45)

Within the participants’ experiences, some of the participants (n = 5) talked about feeling reluctant to seek future medical appointments, or simply sought medical care only if deemed completely necessary.

I wasn’t really comfortable with him then because of how he just openly said such a thing . . . now I don’t go to the doctor unless it’s absolutely necessary. I wouldn’t say that every time that something is wrong I always think back to that experience, but I’ve never really felt comfortable with him anymore since that day. I just feel awkward around the doctor, and I never felt that way around doctors before. (Carol, age 18)
I’m very reluctant, like that was sort of my last bit . . . I feel like I kind of don’t have a reason to seek out medical advice at this point anymore because I feel like it hasn’t done anything for me . . . I’m done with that. (Blank, age 24)

Joyce’s experience of her doctor complementing her on her weight prior to the realization that she was dealing with an eating disorder provided a more specific example of the potential adverse affects of doctors’ weight-based interventions.

Going to the doctor made me aware of weight. I wasn’t nearly as aware of weight before, just measurements . . . I felt a lot better after the visit ’cause I thought maybe I had lost 10 pounds max, and then when she said how much I had lost I was happy. And she complimented me on how I looked at the beginning, before she realized how severe [the eating disorder] was, so I was extremely happy. I was very proud of what I had done . . . after that I kind of felt like everyone was lying to me when they wanted me to gain weight, that’s when I had a lot more negative feelings. (Joyce, age 18)

Contesting Responses

Under the third theme of the Patients’ Self and Body Experiences in Relation to the Doctor-Patient Interaction category, entitled Contesting Responses, many participants (n = 7) described different responses related to resisting their doctors’ particular interventions or weight-related advice.
So because I have a sense of humour and that’s how I deal with things, I said, “Well, do you think my tumour could be like 40 pounds?” I was joking and he goes, “No, but you could stand to lose 40 pounds,” and I said, “Oh okay, well you could stand to grow some hair so I guess that gives us both something to do!” Then he went on and he’s like, “Well have you ever tried to lose weight?” And I said, “Yes, I have, I tried the Bernstein Diet, which if you enjoy starving yourself and want to gain back all your weight it’s a great thing to do.” He goes, “Oh so there is a skinny person inside of you,” and I was like, “Wow, thank you sir” . . . but at least I got my dig in. (Les, age 45)

I think I came in for a prescription and flu medication . . . he started talking about food, what do you eat and it’s like well I pretty much eat everything now. It’s past the stage of changing, like I don’t weigh food anymore, I’m not going to do that, I don’t even own a scale. If something breaks then you know it’s time to cut back. . . . It’s like maybe he’s jaded being in that profession and I’m jaded seeing him, so it’s a two-way thing, right, we’re both jaded. (Clair, age 42)

I could be coming in for a cold or a vaccination or something and it’ll be like, “Oh you look thin, gain a couple of pounds.” . . . It’s the same response that I have when anybody says anything because it’s been so constant my entire life it’s almost like a defense mechanism, my mind just checks out because it’s like, okay, here we go . . . say what you need to say and I’m just going to keep doing what
I’m doing. I’ve had that attitude for a while... you know that nothing’s going to change. (Mary, age 26)

Invalidating and Dehumanizing Experiences

Under the fourth theme of the Patients’ Self and Body Experiences in Relation to the Doctor-Patient Interaction category, entitled Invalidating and Dehumanizing Experiences, many participants (n = 10) described weight-related interactions that lacked supportive medical environments. For example, several participants (n = 4) described invalidating experiences whereby their doctors did not acknowledge their weight-management efforts.

I’d really tried and I wanted him to be proud of me, I just wanted him to recognize, as a doctor of all people, how hard it is to lose that weight, and I had done it, and I was on my way, and you know honestly, if he’d just turned and said, oh wow, you’re really working hard, keep it up, just some validation, but I was still overweight, I was still a problem... I just felt invalidated across the board. (Madeline, age 44)

I have always been overweight and I felt that she doesn’t even see that my progress is coming along, and she didn’t really congratulate me on losing weight. I had lost a little since the last time I saw her... I felt like I wish she’d given me some positive reinforcement for the strides I’d already made instead of just being like, “Oh you have to do more.” Because I was trying! (Jessica W., age 22)
Interestingly, Blank had an experience of doubting herself when her strides made toward a healthy lifestyle were invalidated and undermined based on the size of her body.

It made me doubt my ability to judge things for myself, because as far as I was concerned, I was pretty active and I had been doing all sorts of stuff, and in her eyes that was not the same metre stick. I thought, okay, well if the entire health profession is following regular health guidelines and have a different perspective on this than I do, than either they’re doing something wrong or I’m doing something wrong . . . it just made me doubt myself. I couldn’t come to an understanding between the two, and I think that’s really hard when you’re trying to be consistent with behaviour. (Blank, age 24)

Furthermore, six participants vocalized the felt sense of being treated or viewed as a number during their weight-related dialogues with their doctor.

I just felt like I was a number, not human, and he was just like, “Ok, next.” And I’m like, “Hello you made notes didn’t you, you should be looking at those,” but no, it’s not even like they’re trying to get to know you now. (Chrystal, age 37)

I felt like just the 60th patient . . . but you need a whole new outlook from doctors and that has to come from within that doctor, to look at their patients as people and see their patients as individuals who are struggling. (Clair, age 42)
Interestingly, both Madeline and Christmas Sweater had contrasting interactions with different doctors, one situation triggering a dehumanizing experience while the other evoked a more humanizing experience.

I felt judged, I felt appraised, so it was on his radar you know. And with my current family doctor I don’t feel like it’s on her radar unless I bring it that way. I don’t feel like I walk in as a 220-pound woman and that’s all she sees . . . I felt as though I wasn’t always being looked at as a number on a scale and she had a holistic picture of my health . . . with him, I felt as though that’s what he saw and god, if I went to go see him today he’d probably drop dead. He’d be like what happened to you, let’s get you on The Biggest Loser! (Madeline, age 44)

I’m like weeping in her office and there was no recognition of that, so I felt like she was being pretty cold and I felt like my thoughts were not received and I felt like there was no airtime given to what my concerns were . . . you just feel like Patient #25 or whatever, you don’t really feel like a person . . . and then with my other doctor it was a completely different story. Everything is really addressed with extreme sensitivity, which it’s nice when you come from one extreme to the other, you feel like you actually have a voice and that somebody cares, somebody is taking care of you. (Christmas Sweater, age 22)

**Reaction to the “Fat” Label**

Under the fifth theme of the Patients’ Self and Body Experiences in Relation to the Doctor-Patient Interaction category, entitled Reaction to the “Fat” Label, half of the
participants \((n = 9)\) talked about how receiving the label of overweight or obese activated negative thoughts about themselves during or after the visit with their doctors.

I think when she actually said the word obese it was like, oh my goodness, I can’t believe I am, but it’s so dumb to say I can’t believe I’m obese, it just sounds so terrible of a word, it sounds so terrible of a label. (Sarah, age 45)

He just told me I’m overweight, and I was just shocked and appalled . . . I knew about being fat and obese but I didn’t think I was approaching that mark. (Carol, age 18)

**Body Esteem**

Under Body Esteem, the sixth and final theme of the category Patients’ Self and Body Experiences in Relation to the Doctor-Patient Interaction, participants discussed a number of experiences where their doctors’ weight-related dialogues evoked negative feelings about their bodies. For example, half of the participants \((n = 9)\) highlighted weight conversations with their doctors that triggered feelings associated with letting themselves go, as if they were not doing enough, or that they were doing something wrong with regards to maintaining an “appropriate” weight.

Prior to coming in I didn’t think I was unhealthy or that I was an unhealthy weight . . . I don’t weigh myself regularly, so seeing that at the doctor’s my immediate reaction was like oh damn it, this really happened . . . I felt embarrassed about it
and just like oh shoot, I really let myself go, this is really bad . . . like how could I let this happen to me? (Rose, age 23)

I just felt bad after ’cause I’m like [sigh] I let myself go, or is this stress, there’s just so many different factors I was going through, that’s why I gained so much weight . . . it was horrible but it was just a reality check. (Chrystal, age 37)

More than half of the participants (n = 11) described how they felt unattractive or uncomfortable in their bodies after their appointment encompassing weight-related dialogues.

You feel like you might have made some progress, you feel like maybe this time I’ve lost some weight. ’Cause you’ve been working at it, but then by the time you get on the scale and you start talking to them you realize nothing has changed or it’s gotten worse. You feel terrible . . . you feel like you couldn’t have been more unattractive, and also you’re young and my body is supposed to be the best it’s ever been right now and it’s the worst and so it’s very unpleasant and unnatural and it was a bad feeling ’cause it affects you mentally and you don’t want to go out and you don’t want to do things. It was not good at all. I felt terrible. (Christmas Sweater, age 22)

I remember going back home after that and telling my roommates I gained 12 pounds and just feeling like definitely not in a good place, that was my main
response, feeling embarrassed and ashamed 'cause like I said, prior to that visit I felt that I was at a good body weight, so it was just unexpected. (Rose, age 23)

Many participants (n = 10) talked about how the doctor’s visit containing weight-related dialogues had impacted their self-esteem or self-confidence.

Well when my doctor talked to me about losing weight, it really struck me as odd 'cause I never saw myself as someone who needed to lose weight . . . it lowered my self-esteem because he told me I was overweight . . . it’s better to be aware than not knowing, but I guess awareness also brings about a lack of confidence sometimes. I’m more aware now and my self-confidence has reduced over time because of that. (Carol, age 18)

It was very insensitive. People who struggle with weight, you throw that in their face, it certainly doesn’t help. We have low self-esteem to begin with . . . that’s part of my struggle to begin with right, so I get in and I’m clearly a little depressed about my weight and that affects what I do, so it just brought that right back up. (Les, age 45)

**Summary of Patients’ Self and Body Experiences**

Patients’ Self and Body Experiences was the second of three core categories that emerged from the women interviewed in the study. Under the core category of Patients’ Self and Body Experiences, three categories emerged: Ongoing Medical, Psychological,
and Social Encounters; Weight-Related Experiences in the Everyday; and Patients’ Self and Body Experiences in Relation to the Doctor-Patient Interaction. Throughout these three categories, participants’ narratives highlighted the important role of context in shaping experiences both outside and inside the medical environment.

The first category of the Patients’ Self and Body Experiences core category, entitled Ongoing Medical, Psychological, and Social Encounters, included five themes: Medical Issues; Mental Health Struggles; Weight Stigma and Discrimination; Societal Influences, Ideals, and Norms; and Cultural and Familial Influences. Beginning with the first two themes, Medical Issues and Mental Health Struggles, many participants described how impactful physical or mental health difficulties were on weight statuses and everyday living. A number of different medical and psychological issues were discussed including Graves’ disease, high blood pressure, ovarian tumours, polycystic ovary syndrome (PCOS), Type 2 diabetes, depression, anxiety, disordered eating, and an eating disorder.

As highlighted throughout the study, participants’ narratives documented how doctors often failed to consider the influences of sociocultural, biological, medical, or psychological issues in weight and body size. Accordingly, participants felt lost as to how to effectively apply weight-related interventions when the more complex underlying issues were not addressed. The third theme, entitled Weight Stigma and Discrimination, showcased participants’ experiences in the general public related to negative assumptions, judgments, and/or discriminatory behaviours about overweight or underweight bodies. For example, many participants felt as though people were disgusted by them, or held inaccurate assumptions that they were lazy, incompetent, or
unintelligent. Naturally, occurrences of weight stigma or discrimination impacted how participants’ experienced their bodies and felt sense of self.

Social Influences, Ideals, and Norms, the fourth theme of the Ongoing Medical, Psychological, and Social Encounters category, highlighted participants’ perceptions of the idealization of women’s bodies and health by Western culture, as well as their personal views on what it meant to be healthy. Many of the women interviewed talked about how the media sold the public an image of health, and utilized this image to instil fear and a sense of urgency for women to conform to unrealistic body standards.

Participants’ views on what health meant to them encompassed a more holistic and balanced view of health, including both mind and body. However, even with such balanced views on health, participants continued to feel the pressures on women to fit within Western culture’s standards of thinness and beauty. A few of the participants described a more recent movement toward body acceptance but agreed that Western culture still had a long way to go. Four participants exhibited protective factors shielding them from internalizing dominant norms related to women’s bodies. Interestingly, the four participants, three of whom were 40 or older and one 24-year-old, talked about their ability to critically detach themselves from societal messages regarding health and weight, which included refocusing their attention on balance, connection, and happiness.

The fifth and final theme, Cultural and Familial Influences, shed light on the significant influences of diverse cultural backgrounds and family traditions surrounding food, weight, and health. Several of the participants’ parents grew up in other parts of the world including Sri Lanka and China. Participants described how their upbringings were influenced by their parents’ navigation through Canadian foods and traditions. One
participant who was born and raised in Nigeria described the stark contrast in cultures with regards to food and views on health, highlighting how “big” was considered beautiful in Nigeria. Participants with second-generation Canadian parents also described how different cultural backgrounds influenced their present-day life regarding food and food habits, and often created challenges in attaining their goal weights.

The second category of the Patients’ Self and Body Experiences core category, entitled Weight-Related Experiences in the Everyday, encompassed three themes: Weight-Related Activities, Struggles, Barriers, and Consequences; Self-Objectification; and Body Surveillance. Within this category, participants shared a number of different behaviours and challenges related to their bodies and weight. For instance, all of the women interviewed in the study experienced weight challenges at one time or another in their lives. Participants discussed the behaviours they used in order to subscribe to a certain weight and the consequences of dieting behaviours, including extreme weight fluctuations and psychological distress.

Two other themes that emerged from the Weight-Related Experiences in the Everyday category, entitled Self-Objectification and Body Surveillance, highlighted the regularity of self-evaluation based on external features such as body size or appearance. For the participants in the present study, self-objectification was often demonstrated through their desire to change their bodies, as well as through body-dissatisfaction and body-consciousness. Sadly, all but three of the women interviewed described experiencing self-objectification in one form or another. Within the Body-Surveillance theme, participants talked about feeling as though their weight or weight-related behaviours were under a watchful eye, either by others or by themselves. The feeling of
shame related to body size, regardless of where body-surveillance originated from, was a common manifestation throughout this theme.

The third and final category entitled Patients’ Self and Body Experiences in Relation to the Doctor-Patient Interaction included six themes: Emotional Reactions; Behavioural Reactions; Contesting Responses; Dehumanizing and Invalidating Experiences; Reaction to the “Fat” Label; and Body Esteem. This category emerged as a foundational platform for highlighting the distinct ways in which weight-related dialogues with doctors can evoke a range of emotional, cognitive, and behavioural responses.

Within the Emotional Reactions theme, participants discussed experiencing various emotions including anger, frustration, embarrassment, shame, discomfort, and shock. Furthermore, across the themes of Behavioural Reactions and Contesting Responses, participants exhibited a range of responses including: feeling actively motivated to implement the weight-related advice prescribed by their doctors; attempting to make behavioural changes but falling back into old habits shortly thereafter; feeling no motivation to implement weight advice; and further yet, participating in the exact opposite behaviours prescribed by their doctors. On the more severe side of the continuum, behaviours included: not returning to their doctors due to the significant rupture they felt within the doctor-patient relationship, and trepidation in seeking future medical consultations.

Pertaining to the themes of Invalidating and Dehumanizing Experiences, as well as Reactions to the “Fat” Label, narratives highlighted participants’ disappointment with the lack of human-to-human experiences with their doctors regarding weight-related care.
Specifically, participants talked about the invalidation they felt after disclosing their weight-loss efforts to doctors, as well as their internal responses to being labelled as overweight or obese. Congruent with many of the other responses participants described in relation to the doctor-patient interaction, participants talked about how these experiences negatively affected how they thought about themselves and their efforts to attain health. Furthermore, as demonstrated by the Body Esteem theme, over half of the women interviewed described the negative impact that the doctor-patient interaction had on their self-esteem and self-confidence.

Demonstrated by the various categories included within the core category of Patients’ Self and Body Experiences are the intricate roles that different life contexts have in shaping participants’ lived body experiences both inside and outside the medical environment. More importantly, the categories included within this core category conveyed the challenges faced by women in occupying their bodies under a cultural lens that objectifies women’s bodies and idealizes only a very narrow and often unattainable range of acceptable weights. Within this context, the words that doctors deliver regarding weight have a powerful impact—often adverse—on the doctor-patient interaction, relationship, and individual felt sense of self. Chapter 5 will move toward the third and final core category of Practice. Within this core category, participants’ experiences illuminated actual weight-related interventions prescribed by doctors, as well as participants’ recommendations for doctors supporting women in this sensitive and important domain of weight-related care.
CHAPTER FIVE

PRACTICE

“Listen more and hear what your patient is saying because that shows that you really do care.”

Jessica R.

Chapter 5, Practice, examined the third and final core category that emerged from the analysis. Two categories emerged from Practice: Practice As Is; and Recommended Modes of Practice (see Figure 11). Within these two categories, participants discussed the weight-related practices they received as well as offered future recommendations for doctors providing weight-related care.

Figure 11. Categories and themes emerging from third core category Practice

Practice As Is

Emerging as the first category under the third core category of Practice was Practice As Is. Five themes emerged from this category: Physical Activity; Diet; Combination of Physical Activity and Diet; Suggested Weights; and Time and
Attentiveness (see Figure 12). Across these themes, participants described their individual experiences with prescribed weight-related interventions from their doctors.

Figure 12. Themes pertaining to the category Practice As Is

Physical Activity

Under Physical Activity, the first theme of the Practice As Is category, 11 participants described physical activity being discussed in one form or another by their doctors; four participants received just physical activity advice. For example, some doctors simply suggested that participants modify their physical activity levels, while others provided more practical suggestions and ideas regarding how to implement physical activity routines into their lives.

I remember she came in after she got the results from all the general check-up and she’s like, “Oh I’ve noticed you gained 12 pounds” . . . to enforce that I should get some more exercise in . . . like recommending exercise is something very obvious. (Rose, age 23)
Her whole thing was making sure that I’m getting 30 minutes of cardio five times a week or something like that . . . so just stressing that whole 30 minutes of cardio five times a week over and over again and that made me go, okay, well I’m active at least an hour a few days of the week, like your advice is not helping me right now. So it was kind of like a hitting-the-wall-repeatedly thing. (Blank, age 24)

Only two of the 11 participants who were prescribed physical activity as a means for weight loss had a doctor explore with them different types of exercise that could be easily and enjoyably implemented into their lives.

She basically said you need to be exercising and then she gave me a bunch of different options that I could take . . . she basically just asked what sort of exercise I liked to do or what I don’t like to do ’cause she wanted to give me a few different options of what kinds of things I could be doing for physical activity. (Jessica W., age 22)

She was trying to get me to write down what I was eating and specific exercise, not just exercise, but what I could do, and so I tried to say things that I knew I would enjoy, like badminton or something like that, and tried realistic about three times a week and not every day ’cause I know I won’t be able to do that. (Sarah, age 45)
Both Mary, who was classified as underweight by her doctor, and Joyce, who was diagnosed with an eating disorder, received weight-related interventions related to decreasing the strenuousness of their physical activity levels.

My doctor was like, “Don’t do cardio,” and I’m like, “But isn’t that good for my health to maintain my heart?” And she’s like, “No, don’t do it, you’ll lose weight and then you’ll be even worse, just go to the gym and lift weights if you want.” But I’m like, “I don’t want to lift weights!” So then it instilled some kind of fear that what if I start doing cardio and I lose another five pounds, which on me would be obvious so I just don’t exercise and then I worry this is probably not the smartest solution. (Mary, age 26)

My doctor thought exercise was good but that it should be less strenuous. Instead of going out for really long bike rides or runs to do yoga and stuff, so that was one of her main pushes, and to do walks and look at scenery and stuff. (Joyce, age 18)

**Diet**

Under Diet, the second theme of the Practice As Is category, 12 participants had doctors suggest diet modifications as part of their prescribed weight-related interventions; five participants received *just* diet advice. Similar to physical activity, doctors’ instructions ranged in the complexity of diet advice, including simply broaching the topic of diet as an area of modification to providing more specific suggestions for participants in adapting their daily caloric intake.
Well just being told you have to change your ways like, you can’t eat this way and you can’t expect the results that you have experienced in the past, that’s not encouraging. It just makes you not want to try at all. (Christmas Sweater, age 22)

We started talking about food . . . and he’s like, “Well you’ve got to cut out all these types of foods you eat,” and his specific advice was to give me a list of foods with some kind of menu chart, kind of a dietary guide . . . but his specific advice was try to follow this dietary measure and cut out the cola and the soda and all the things you love. (Clair, age 42)

Similar to the physical activity theme, Jessica R. and Mary, who were categorized as underweight by their doctors, and Joyce, who was diagnosed with an eating disorder, were advised to increase their caloric intake.

He started talking to me saying, “Your BMI is kind of low for females,” and so I explained to him, “Well in my family a lot of us are like that.” He was like, “No, but it is too low . . . you need to eat more” . . . it was kind of like he was lecturing me the whole time just trying to get me to eat more. (Jessica R., age 27)

She was giving advice like get your weight up ’cause I told her I can’t get my weight up, it’s not possible, so she’s like, “Have your three large meals a day and then fill it up with snacks.” I’m like, “I can’t eat that much either, like that’s a lot to keep eating.” (Mary, age 26)
She thought that I didn’t need to lose any more weight . . . so she thought that if I was having trouble eating in general that I should have more high-calorie dense foods, so a lot of nuts and stuff, that was her first suggestion . . . I really didn’t like her suggestions about eating nuts and stuff ’cause I didn’t like nuts before and I thought that her actual eating advice was very non-helpful. (Joyce, age 18)

Congruent with the topic of diet, three participants’ doctors asked them to keep food diaries or food logs.

In terms of eating, she just told me that it might be good to keep a food log, and even if I didn’t come back and consult with her it would be good for me just to see what I’m eating, how much I’m eating, when I’m eating, that sort of thing, so that’s the advice that she gave me. (Jessica W., age 22)

She wanted me and my mom to write down what I had been eating for the last three days, and then she had me say what I had been eating so we did that, and she thought it wasn’t enough food. (Joyce, age 18)

Four participants were provided with suggestions to explore community resource options including weight programs and nutritionists.
My previous doctor said, why don’t you try something like Weight Watchers, and I tried that for a little bit and it was kind of successful but it wasn’t permanent, it wasn’t long-term. (Sarah, age 45)

She told me to go see the nutritionist because I’ve been vegetarian for 10 years plus, so I was saying I’m fairly knowledgeable about that but her whole thing was just making sure that I’m on the right page. (Blank, age 24)

**Combination of Physical Activity and Diet**

Under the third theme of the Practice As Is category, entitled Physical Activity and Diet, seven participants talked about receiving a combination of both physical activity and diet modifications as their prescribed weight-management activities.

He just says exercise and try to eat healthy and stuff like that, but I already knew that anyway going in there . . . he doesn’t really say a lot. (Juliette, age 40)

Basically, it was very short, like you need to eat better, you need to change your eating, you need to exercise, can you exercise? (Ashley, age 23)

**Suggested Weights**

Under the third theme of the As Is category, entitled Suggested Weights, five participants described how their doctor identified their supposed ideal weights based on their height.
He said for my height I should really be around 110-ish or 120 at max but of course I’m way past that . . . so if you’re hovering around 130/140 it’s kind of like 20 pounds overweight. (Jane, age 27)

She gave me the advice that in order to maintain no symptoms, essentially that I should keep my weight to 140 maximum . . . it was pretty verbal and she didn’t really give me much advice on how to do it, just keep it under 140. (Emily, age 37)

**Time and Attentiveness**

Under the theme of Time and Attentiveness, fourth in the Practice As Is category, four participants shared their positive experiences with particular doctors who provided them with quality care and a comfortable medical environment in which to explore weight issues and solutions.

He’s just like a lot more gentle, he gives you tons of time and there’s a lot more discussion about how you’re feeling and stuff, very into the psychological impact of all these types of things, so we talked a lot about how I was feeling about it . . . he always said it’s a moment in time, it’s not forever, this is the worst you’re going to feel and you’re going to get better. (Christmas Sweater, age 22)

He’s good, he’s a nice doctor, he’s very attentive. He wouldn’t rush through his appointments so he’d spend time . . . he also practices holistic medicine, so he does both. If you were willing to take that sort of advice, but he doesn’t force it on
you. He’s just saying, if you are willing to look at alternative ways by all means.

(Jane, age 27)

**Recommended Modes of Practice**

Recommended Modes of Practice emerged as the second category under the third core category of Practice and included five themes: Quality of Human Dialogues; Consideration of Personal and Social Context; Professionals as Facilitators of Change; Informed Plans; and Doctors’ Training (see Figure 13). Within this category participants provided thoughtful suggestions for doctors to consider when dialoguing with women regarding weight-related topics. Many variables were highlighted including ways of being with patients, open dialogues, contextual considerations, resources and direction, and larger systemic issues. Participants tended to describe these themes in a very interconnected manner. Therefore, some of the quotations will include overlapping themes and subthemes.

*Figure 13. Themes pertaining to the category Recommended Modes of Practice*
Quality of Human Dialogues

Under the first theme of the Recommended Modes of Practice category, entitled Quality of Human Dialogues, six subthemes emerged: Human-to-Human Interactions; Thoughtful Delivery and Tone; Non-Judgmental and Empathetic Communications; Personable; Sensitive; and Two-Way Conversations. Within the Quality of Human Dialogues theme, participants talked about the many ways in which doctors could interact with patients to create an environment encompassing quality exchanges and strong connections.

Human-to-human interactions. Under the first subtheme of the Quality of Human Dialogues theme, entitled Human-to-Human Interactions, all 18 of the participants described various suggestions for doctors related to treating their patients as human beings who are struggling.

It’s really all about how you treat the person. Are you treating them as a person? Are you treating them well? Are you acknowledging that there are challenges? And things like that. So it’s really about bedside manner . . . somebody that’s sensitive, takes their time with you, acknowledges that you are a person, you’re an individual, and your needs and your body and your mind are not the same as the standard person or the average person. (Christmas Sweater, age 22)

Try and relate to your patient on a personal level, really relate and not just see them as the 60th patient . . . look at your patients as people and see your patients
as individuals who are struggling. There are people out there who do want to change and they need that support. (Clair, age 42)

I think they should spend more time with you, be more open and understanding. If you have a weight problem or a psychological problem, maybe they could be a little bit more like your friend as opposed to just your doctor, somebody that’s there for you on an interpersonal level. (Juliette, age 44)

**Thoughtful delivery and tone.** Under the second subtheme of the Quality of Human Dialogues theme, entitled Thoughtful Delivery and Tone, all but one of the participants \((n = 17)\) suggested that doctors be mindful and considerate of the ways in which they delivered weight-related dialogues.

I’m the type of person who does not respond well to negative, even if it’s something good for me that I need to be hearing. If it’s delivered in a negative manner, or if I perceive it to not be nice or caring, then I disregard it. So I require a lot of sensitivity in delivery . . . if they could talk to you on your level, don’t talk to you like you’re a child, don’t use huge words that you don’t understand, really communicate with you, understand where you are at intellectually, and then sort of match that. I appreciate that. (Christmas Sweater, age 22)

Be more sensitive in the way you deliver the information. I guess the key point is to deliver it in a manner that is warm and professional, making the comment as it
pertains to the person’s health . . . that’s the biggest thing and that will also contribute to how seriously patients take you, how seriously they follow up on your advice. (Mary, age 26)

If my doctor is positive, I might go home and be motivated to eat differently or exercise differently . . . you think, I’ll try that because he recommended it, he looked into it so I’ll try it. That’s the strongest motivation. (Clair, age 42)

**Non-judgmental and empathetic.** Under the third subtheme of the Quality of Human Dialogues theme, entitled Non-Judgmental and Empathetic, the majority of participants $(n = 16)$ discussed suggestions for doctors to incorporate treatment that is free of judgment and moves closer toward empathic communication and understanding.

I think the main thing is you don’t want your patient or whoever’s daughter to feel bad about their lifestyle . . . you want for patients to be able to say things to you that they might feel weird about saying to somebody else, like saying, I have a really bad problem with poutine, and that doctor not being like, you fucking fat ass, but being non-judgemental and supportive. (Ashley, age 23)

I guess you need a therapist/doctor all rolled up in one . . . a little bit more empathetic, maybe there’s other things in your life that are preventing you from focusing on your weight . . . be supportive on some emotional level, don’t criticize and certainly do not judge. (Claire, age 42)
**Personable.** Under Personable, the fourth subtheme of the Quality of Human Dialogues theme, many of the participants \((n = 12)\) suggested doctors try to be more amiable and warm in their interactions with their patients.

Just the way they speak to you, not to make it so clinical, touch more on a human perspective, even just say, “You’re not the only one, there’s a lot of other people that are going through this.” So for them to really relate and want to understand more things about you here. (Chrystal, age 37)

Someone who’s personable, sociable, who doesn’t just say, “Tell me about your health” . . . someone who’s trying to get to know you, which a physician should be doing anyway ’cause that’s important in diagnoses. (Rose, age 23)

Be more personal about it, more sensitive, because each individual is different . . .

I think that a doctor should know about where you come from. (Carol, age 18)

**Sensitive.** Under Sensitive, the fifth subtheme of the Quality of Human Dialogues theme, the majority of participants \((n = 17)\) talked about the importance of doctors conveying sensitivity when dialoguing with women about their weight.

Especially with women, sensitivity is key. Even if you’re a perfect weight you never feel that way, and even if you’re perfectly healthy you never feel like you’re at a good weight, so you have to be really, really conscious of how that’s
going to affect your patient mentally, and if anything, be overly sensitive and really keep tabs on how they are mentally in dealing with their weight . . . open that dialogue for sure. (Christmas Sweater, age 22)

Be able to understand that it’s not cut and dry. If there is a magic pill that could make me lose the weight I’d be all for it you know, so just to be sensitive, we need that sensitivity . . . be able to understand that that’s not just a fat person you’re looking at. (Les, age 45)

I think there needs to be an understanding that regardless of where you fall in the spectrum of weight, that weight in general is a sensitive topic particularly for women, so wherever they fall just have sensitivity about how you approach it. (Mary, age 26)

Within the Sensitivity theme, Carol, who was born and raised in Nigeria, highlighted the suggestion for doctors to be more culturally sensitive when talking to women about their weight. Carol previously talked about feeling shocked and appalled by the casual manner in which her doctor “threw around his words” regarding her weight status and recommendation to lose weight.

Understand that different women are different, so even if I like more information some people might be very sensitive and think that the doctor is harping on them. I just think be more personable, because doctors know a lot about their patients
and if they are bringing up weight then they should know who their patients are . . . they should be more aware of cultures, they should be more aware of the media . . . lead into it instead of just saying that you need to lose weight. Be able to make the patient comfortable because that’s a very sensitive issue (Carol, age 18)

**Two-way conversations.** Under the sixth subtheme of the Quality of Human Dialogues theme, entitled Two-Way Conversations, all 18 of the participants highlighted the importance of doctors making the time and effort to have open dialogues with their patients, encompassing thoughtful inquiry and genuine listening.

I think a doctor should be compassionate, allow the client to talk about their reasons for why they’ve gained the weight, consider lifestyle, consider available resources, and consider the clients’ goals because I think that’s really reflective, too. (Ashley, age 23)

If you get to know somebody better you create a bigger, stronger sense of trust, because a lot of the times, doctors are really quick when they talk to you . . . if they just stopped for a second maybe they might actually figure out that there’s a factor that is causing this . . . so the quality of care goes down when everyone is rushed, it goes down significantly. (Mary, age 26)

I think the more questions the doctor first asks the patient, the more seriously the patient can take the doctor. You can’t just look at a chart and come to a
conclusion without first asking several questions from the patient . . . it’s important to take people more seriously and realize it’s more of a two-way conversation, and then it feels more motivating to take that advice if you feel like you’re on a team with your doctor. (Jessica R., age 27)

Consideration of Personal and Social Context

Under the second theme of the Recommended Modes of Practice category, entitled Consideration of Personal and Social Context, four subthemes emerged: Understanding Lifestyles; Attentive to Mental Health; Mindful of Disordered Eating Backgrounds and Weight Preoccupations; and Appreciation of Systemic Factors. Within this theme, participants highlighted the importance of doctors considering and understanding the intricacies of human life, and how context should play an important role in informing any weight-related practices.

Understanding lifestyles. Under the first subtheme of the Consideration of Personal and Social Context theme, entitled Understanding Lifestyles, the majority of the participants (n = 16) suggested the significance of doctors exploring their patients’ individual lifestyles in order to provide more extensive, considerate, and practical treatment plans for weight management.

I think definitely considering the social and psychological aspects to weight . . . ideally if you could consider where that person is in their life and what time they actually have to dedicate to these things you’ll be much more successful . . . also
how to mitigate stress, that’s huge for people, and I think that’s the thing that is not addressed. Sure I know what healthy food is because I’ve been doing research for a thousand years, I know how to exercise ’cause I do it all the time, but the question is, how do you put these together when you’re having a terrible day, or when you don’t have any time to pick up healthy food? (Blank, age 24)

As a doctor, if I had a patient and she said to me, I want to lose weight, I’d talk to them about her life, I’d say, talk to me about your weekend, you’re 20-whatever, you go out with your friends on the weekend and that makes sense . . . really taking lifestyle into consideration, helping the person implement something realistic. (Ashley, age 23)

Really try to get an idea of the patient’s real lifestyle and what they’re actually going to do, because I find that a lot of doctors give advice that’s good advice, but it’s not realistic for the actual patient’s lifestyle. I think that you have to work with the patient to find the solutions that are going to work in their life because, at the end of the day, eating well and exercising for a lot of people falls by the wayside. (Jessica W., age 22)

**Attentive to mental health.** Under the second subtheme of theme, entitled Attentive to Mental Health, the majority of participants (n = 16) described suggestions to doctors that encompassed exploring and considering the mental aspects of health and how weight and emotions are intricately entwined.
Just be more sensitive in the way you approach somebody, especially find out the situation they’re in ahead of time. If you know someone’s depressed and you’re going to bring weight up, be very careful in the way you bring it up because that can affect that person mentally. (Chrystal, age 37)

Doctors would do well to address the emotional aspects of individuals a lot more . . . potentially focusing on strengths that the person already does have and sort of trying to foster a bridge between that and this ideal that they medically have in their opinion, and also realizing that they do have an opinion, although it’s educated, it is in fact an opinion and not a fact, make it more client-centred rather than medicine-centred. (Blank, age 24)

**Mindful of disordered eating backgrounds and weight preoccupations.** Under the third subtheme of the Consideration of Personal and Social Context theme, entitled Mindful of Disordered Eating Backgrounds and Weight Preoccupations, several participants ($n = 5$) pointed out the importance of doctors being cognizant of patients’ histories in terms of eating disorders, disordered eating, or weight preoccupations.

I had an eating disorder and I was also bulimic and over-exercised a lot. After I stopped that I regained a lot of weight, and so I’ve had this sort of issue. For me, I need a doctor who’s fairly sensitive to food issues and weight issues. (Jessica W., age 22)
I think each scenario is unique and has to be like looked at differently . . . if you’re curious about eating disorders or if your patient has an eating disorder, don’t compliment the weight at first, ask the questions you need before you start commenting on weight because that’s a big thing for me. (Joyce, age 18)

**Appreciation of systemic factors.** Under the fourth and final subtheme of the Consideration of Personal and Social Context theme, entitled Appreciation of Systemic Factors, several participants (n = 6) talked about systemic variables that needed to be addressed in order to provide effective weight-based care.

Health behaviours happen in contexts. I believe that most determinants of health are environmental. Instead of putting the onus on willpower and simple prescriptive interventions in order to make someone healthy, we ought to see how we can leverage different aspects of their environment to enable these desired behaviours. Or, better yet, educate people on behaviour-change models and social forces so that they can critically do this leveraging themselves. In this way it’s not about “avoiding sugar” or “doing 30 min. of cardio a day.” It becomes about “I have problem eaters in my family,” “my stress level at work makes me too tired to have willpower,” or “media depictions of women are oppressive and disempowering.” It’s a lot easier to combat the problem when you realize why it arises rather than just trying to hold on with willpower that you don’t even have and then fall off the wagon and end up more emotionally depleted than when you began. (Blank, age 24)
Know that people who are overweight, that it’s not just one thing triggering it. Ask deeper questions as to why . . . because the eating and exercise, yeah those are tools that I think obviously we need to apply to get healthier, but you should find out the real problem of what’s causing that person to be overweight in the first place. I don’t think people become overweight just for no reason. (Sarah, age 45)

More and more doctors are going to see people who have weight issues. Recognizing it’s a systemic problem, that it’s not as simple as eating too much, recognition of it being a holistic issue, is most important. (Madeline, age 44)

**Professionals as Facilitators of Change**

Under the third theme of the Recommended Modes of Practice category, entitled Professionals as Facilitators of Change, six subthemes emerged: Normalizing; Encouraging; Exploring Why Patients are Struggling with Weight; Explaining the Medical Issues Associated with Particular Weights; Working Collaboratively; and Focusing on Health Versus Weight. Within this theme, participants communicated how doctors could create an environment of increased openness, motivation, and teamwork, which in turn could help facilitate desired weight-related changes.

**Normalizing.** Under Normalizing, the first subtheme of the Professionals as Facilitators of Change theme, many participants ($n = 11$) described an ideal environment where their doctors normalized the topic of weight and weight-related struggles by
incorporating standardized questions as part of a routine check-in with every patient, regardless of weight.

I would say ask before you prescribe. Raise the issue with everybody, not just overweight people. Raise the issue with underweight people, raise the issue with normal weight people, you can say, “This may be a sensitive issue but I ask all my patients how they feel about their weight as part of an overall examination, how are you feeling? How are you feeling about your level of exercise? Are you getting enough sleep?” So make it a non-stigmatizing issue and keep a really good non-judgemental relationship so that when people do have trouble they can come to you. Otherwise they may leave you and put off getting the proper health care for themselves and feel ashamed of their bodies. (Madeline, age 44)

Make it a part of the regular thing, like when you do your annual check-up, and if you have to do blood work, it should just be part of the routine, like we’re going to take your blood pressure, we’re going to take your weight, so then you know, part of my annual check-up is they’re going to talk about your weight, are you healthy, how often are you exercising, what kind of exercises do you do and your dietary habits, are you stressed . . . make those questions part of that whole package. (Sarah, age 45)

**Encouraging.** Under the second subtheme of the Professionals as Facilitators of Change theme, entitled Encouraging, many participants ($n = 12$) suggested that doctors
attempt to offer more encouragement for their clients regarding weight issues. The participants described how receiving encouraging support could go a long way in terms of motivating people to make important changes in their lives.

Well I think it’s important to make it a positive conversation, an encouraging one like, “Hey, I want to help you, you’re not in a bad place, but this is how you can keep yourself healthy.” For me, I respond better to more helpful feedback and more encouragement. (Juliette, age 44)

A little bit of cheerleading goes a long way. Make your patients want to make you proud of them; don’t shame them, we know that doesn’t work, so that would be my advice, be cheerleaders for them, meet them at their goals, be a good facilitator of resources for them, be someone who’s non-judgemental and can be supportive and normalizing. (Madeline, age 44)

**Exploring why patients are struggling with weight.** Under the third subtheme of the Professionals as Facilitators of Change theme, entitled Exploring Why Patients are Struggling with Weight, many participants \((n = 10)\) suggested that doctors spend more time investigating the reasons behind patients’ weight, as this could lead to more informed goals and increased adherence to weight-management plans.

Someone to talk to me about why you think this happened, maybe sort of nicer than that but say, “Let’s talk about some factors that might have contributed to
this.” I’d want someone to talk to me about those factors and say where I was in life and work with me in terms of a plan that would fit that lifestyle. (Ashley, age 23) I think context is very, very important. For example, if someone gained a lot of weight because they’re taking a medication that makes them gain a lot of weight, I think that’s important to recognize. I don’t think you should point out a problem without understanding the whole situation. (Rose, age 23)

**Explaining the medical issues associated with particular weights.** Under the fourth subtheme of the Professionals as Facilitators of Change theme, entitled Explaining the Medical Issues Associated with Particular Weights, many participants \((n = 7)\) recommended that doctors communicate the medical issues associated with heavier or thinner bodies. Participants suggested that when doctors are able to describe the underlying medical issues, patients might feel more inspired to make meaningful changes.

If they could explain why being thin is a problem, so if a doctor was like, “Well if you’re under this amount you’re at an increased risk for this, let’s run some blood work,” then I’d probably more inclined to be like, “Okay, run whatever tests you need, see what’s going on.” So approach it in more of a medical manner like I was saying, it’s a problem for this reason, it can affect your health in this way, that makes sense. (Mary, age 26)
I’m happy to hear what’s going on in my body so I prefer when things are sort of more scientific, saying this is why, explaining why we’re doing it, and this is what’s happening in your body on the cellular level, or whatever the case may be, and that’s why you’re doing it. I’m not the type of person who can easily take advice if I don’t know why it’s being given or how it works. (Christmas Sweater, age 22)

Working collaboratively. Under Working Collaboratively, the fifth subtheme of the Professionals as Facilitators of Change theme, all 18 of the participants talked about their desire to have doctors work with them as a team to explore and plan what to do next.

Working collaboratively to help you reach that goal, because you’re not going to reach it by yourself. That’s where the support and the understanding kicks in. And if my doctor is positive, I might go home and be motivated to eat differently or exercise differently. (Clair, age 42)

Know that there are reasons behind weight and that they need to find out what those reasons are . . . I envision it’s trying to do the research with the person, figure it out and actually taking the initiative to point the person in the right direction ’cause if this is part of the problem then you need a solution. (Les, age 45)
**Focusing on health versus weight.** Under the sixth subtheme of the Professionals as Facilitators of Change theme, entitled Focusing on Health Versus Weight, over half of the participants ($n = 11$) provided suggestions that incorporated doctors being conscious of framing weight-related interventions in light of self-care and health versus a preoccupation with body size.

Remind them, especially a girl, that they’re not defined by their weight . . . when that person loses weight I think what’s really important is you don’t make it about the weight, you make it about the person. You might say, “Oh you look healthier now,” or “Do you feel better?” (Ashley, age 23)

Not promoting like, hey you gained weight, lose it now, but to promote a healthy lifestyle as opposed to just losing weight ’cause there are a lot of unhealthy ways to lose weight . . . I see both sides of the argument in that you want people to be healthy and obviously being obese is bad, but you don’t want to make it a pathological concern for people to the point that the thinner you are the better. (Rose, age 23)

**Informed Plans**

Under the fourth theme of the Recommended Modes of Practice category, entitled Informed Plans, six subthemes emerged: Creativity and Open-Mindedness; Individualized Plans; Verbal Information and Advice; Written Information and Advice; Guidance and Direction; Follow-Ups and Referrals. Within the Informed Plan theme,
participants provided suggestions pertaining to weight-related information, advice, direction, and community supports.

**Creativity and open-mindedness.** Under the first subtheme of the Informed Plans theme, entitled Creativity and Open-Mindedness, many participants \((n = 13)\) discussed desiring doctors who were able to think outside the box and have the knowledge and openness to be innovative in their responses regarding weight-management interventions, and to not just provide the generic “eat less, exercise more” weight prescription.

If doctors could be a little more creative with their suggestions. Maybe he can suggest trying something that you haven’t tried before, not the usual suspects, but being creative with you . . . I think it would be good doctors if updated their brains a little with the research . . . become more knowledgeable about it and offer more of a follow-up if he sees it as a big issue. (Jane, age 27)

I would like a doctor who’s really up with the times . . . someone more open-minded in terms of knowing it’s not just one thing affecting your weight. . . . Ask questions and to try to anticipate, or see if your patient wants to discuss something new or different. (Clair, age 42)

**Individualized plans.** Under the second subtheme of the Informed Plans theme, entitled Individualized Plans, many of the participants \((n = 15)\) advocated for doctors to
provide more personalized and tailored weight-management plans for their patients, as this would provide more realistic goals for patients to implement and achieve.

I feel like physicians really need to know their individual patients, that there’s not a cookie-cutter way of treating everyone, and they don’t typically have that . . . not everybody has the same amount of money coming in so it becomes more difficult . . . it’s important to change the plan to match the person’s lifestyle and provide more of an active plan if weight is such an actual problem. (Mary, age 26)

I would want advice tailored to me, not to everybody that’s overweight, ’cause not everybody eats the same way . . . you want something more personalized, clear, and tailored to you . . . maybe patients would be more inspired to actually try it if the advice is tailored to your own lifestyle. (Clair, age 42)

**Verbal information and advice.** Under the third subtheme of the Informed Plans theme, entitled Verbal Information and Advice, all 18 of the participants suggested that if doctors indicate weight is an issue, then they should provide some form of weight-management information or advice.

I would suggest doctors give concrete, prescription-style information, a combination of advice about exercise and food . . . for example, I wish he would be more specific in saying maybe the proportion is wrong, or if he asked me what I ate in the last two weeks, give me a meal breakdown and then target that. I just
wish they were more specific. Honestly, for a patient in the general population, we don’t know enough. (Jane, age 27)

Give good advice, maybe tell people what they shouldn’t be eating. I think that’s a big thing, knowing what they should be eating. It would help if doctors became more knowledgeable in the weight and nutrition stuff instead of just general medicine if they are indeed treating weight issues. (Juliette, age 40)

I would like more specific advice like, “Why don’t you try eating more of this to help you to sleep better, or try drinking more water, or try exercising in the morning and then you can boost your metabolism,” something more specific rather than the general advice given. (Rose, age 23)

**Written information and advice.** Under the fourth subtheme of the Informed Plans theme, entitled Written Information and Advice, just under half of the participants ($n = 7$) suggested that doctors provide written information regarding weight-management interventions that patients could take with them and refer back to at a later date.

I would say if it’s very specific suggestions maybe give reading material, I think it would be helpful if they can give that on paper so a person can go and look it up, because sometimes verbal just slips your mind once you walk out the door. (Jane, age 27)
I really like to get as much information as possible, so since patients are there to get information about their health anyway, I would have benefited from getting pamphlets or a website to like go to or something to start with. As much information as possible . . . the doctor is someone whom I should trust and who should give me all the information that I need. (Carol, age 18)

**Guidance and direction.** Under the fifth subtheme of the Informed Plans theme, entitled Guidance and Direction, many participants \((n = 15)\) suggested that doctors provide assistance and support by pointing patients in the right direction with regards to weight-management information and practical resources.

I would like more recommendations of how I should get there, like direction on what or where to go. I’m glad that you brought it to my attention but then that’s it? The rest just feels like I need to come up with it on my own, so yeah, I’d like there to be some direction. (Nine, age 22)

I would just like more discussion of what I’m doing if it’s healthy, just basic direction, like how you calculate your food groups, exercise. It’s kind of difficult for me as a layperson with no medical background so just maybe point to Health Canada sites, or where to find what is currently generally accepted for a good diet or a good weight to be, and so on. (Emily, age 37)
Follow-ups and referrals. Under Follow-Ups and Referrals, the sixth subtheme of the Informed Plans theme, 13 of the participants suggested that doctors provide follow-up appointments to increase accountability and motivation, or to provide referrals when weight-related intervention is out of the scope of their knowledge base or practice.

If I were a doctor, I would say it would be helpful to have a follow-up appointment and tell [patients] that this is why I think you should. I would explain the purpose of the follow-up is to give them solutions, and I would say let’s meet in three or four weeks and talk about how these are being implemented and at that point we can also reassess that if something isn’t working for you, we can figure out what is. Just make that individual aware that I was always on their side. (Ashley, age 23)

If the patient seems to be lost, let’s say they’ve been told previously that maybe they’re overweight, and then they come back and they’re still overweight, maybe you’re more active in pointing them to resources, maybe Health Canada pamphlets . . . a referral to a dietician or some other more detailed material can then be given, as general practitioners probably don’t receive much training in this specific field as a specialist. (Emily, age 37)

Mary talked about the need for alliances to be built between the community and health care professionals in order to provide more efficient, comprehensive weight-related care.
There needs to be more collaborations between clinicians, they need to know what else is out there, who they can refer their patients to, and different things that are in the community . . . going to outside sources for referrals, there should be more of an active plan if weight is such an actual problem in just general practice medicine than they should have a real system in place to deal with it, not just this weird way they’re doing it now. (Mary, age 26)

**Doctors’ Training**

Doctors’ Training is the fifth and final theme of the Recommended Modes of Practice category. Within this theme, over half the participants (n = 10) discussed necessary changes to be made within the medical education system in order to train doctors in providing more patient-centred care. For example, participants talked about the need for increased training in empathy, compassion, and sensitivity toward the emotional wellbeing of patients.

Doctors would do well to address the emotional aspects of individuals a lot more. Positive psychology delves deeply into the power of emotion as a source of motivation and healing. Words like “compassion” and “vulnerability” don’t get thrown around at the doctor’s office these days. That might be something that should be part of medical training that a doctor ought to be aware of with patients. (Blank, age 24)
I think it’s a lack of training . . . they talk about obesity and they talk about the BMI, but it’s such a minute piece in the education portion for medical professionals, and I know that from experience. For such a gigantic problem that obesity is, it is not worthy of any kind of education even in the medical field? Where is the piece about what women deal with? . . . There is no training in schools for empathy or even an understanding of what that means. You can’t have the sensitivity if you don’t have the knowledge, and you don’t have the knowledge if there’s no training. (Les, age 45)

Other participants discussed how the medical education curriculum for doctors should incorporate specific training in effective weight-management practices.

I thought it is shocking that doctors are not trained in things like weight management for patients. Obesity is so common these days and doctors seem to know little except to measure a patient’s weight and measure their height and then say the patient is overweight. I believe perhaps real change will have to come from medical school curriculum reform. Doctors should also play the role of educator in order to affect change agents in the fight for good health. (Jane, age 27)

I think people are thrown weight-management advice from all walks of life: friends, family, media, and so I’ve been the recipient of much of this type of advice, and I think that doctors come from a more authoritative point of view and
they probably need a bit more training to approach patients with weight advice, especially female patients. (Emily, age 37)

Related to increased training for doctors on weight-related interventions, Clair discussed how it would be beneficial for doctors to gain further training on skills that would support creativity and open-mindedness when approaching weight-related care.

I’ve had enough encounters with health care to know it’s in shambles right now. You get stuck with one perspective of how to treat weight . . . nobody’s really interested in looking at any other angle and I think it’s important for them to have new perspectives, think outside the box, maybe education, I don’t know, education in terms of updated training in med schools. (Clair, age 42)

**Summary of Practice**

Practice was the third and final core category that emerged from the present study. Under the core category of Practice, two categories emerged: Practice As Is and Recommended Modes of Practice. Throughout these two categories, participants revealed the many ways in which their doctors prescribed weight-management interventions, and based on these experiences, expressed thoughtful suggestions for doctors to consider when providing weight-based care to women in the future.

The first category under the third core category of Practice was entitled Practice As Is. This category encompassed five themes including: Physical Activity; Diet; Combination of Physical Activity and Diet; Suggested Weights; and Time and
Attentiveness. Demonstrated in this category was the frequency of prescribed weight-management advice that included either physical activity, diet, or a combination of both. Several participants also mentioned that their doctors recommended for them an ideal weight bracket to strive for in order to reach a healthy weight based on their height.

The recommended advice from doctors in both the Physical Activity and Diet themes varied in the amount of detail provided, as well as the individualization of the advice. For example, some participants received the suggestion that either diet, exercise, or both were in need of modification; however, often times there was a lack of information provided on how to implement this advice. Most participants who received exercise or diet recommendations were simply encouraged to increase their physical activity level and decrease their caloric input. On the other hand, participants who were identified as underweight by their doctors were often instructed to decrease their physical activity levels and increase their caloric input.

A few of the participants talked about having doctors who were willing to explore weight-management activities that were realistic, enjoyable, and more likely to be incorporated into their lives. In these circumstances, participants who received more specific advice expressed appreciation and gratitude toward their doctors for making the effort to individualize their recommendations. Positive experiences were also highlighted when participants received more time and attentiveness within their visits. Importantly, they described how time and attentiveness conveyed a sense of care, and allowed for a more comfortable environment in which to discuss weight-related topics.

Emerging as the second and final category under the core category of Practice was Recommended Modes of Practice. Recommended Modes of Practice included five
themes: Quality of Human Dialogues; Consideration of Personal and Social Context; Professionals as Facilitators of Change; Informed Plans; and Doctors’ Training.

Participants voiced valuable suggestions for doctors to consider when dialoguing with women regarding weight-related topics. These included important patient-interaction skill sets, awareness of context, collaboration and support, and resources and direction.

Throughout their interviews, participants discussed a number of suggestions for doctors that encompassed clinical skills and supportive ways of being with patients. For example, each of the participants’ narratives conveyed the desire to be afforded one-to-one interactions that involved compassion and validation for the struggles present in their journeys. Doctors’ delivery and tone was also identified as being significant to care.

Participants suggested that doctors be mindful and considerate regarding the extreme sensitivity of weight for women, regardless of where one falls on the weight spectrum, and approach these weight-related conversations with professionalism, warmth, and care.

Participants also described an ideal doctor-patient relationship where the doctor was personable, non-judgmental, and empathetic in nature, thus cultivating a comfortable environment in which to openly discuss, normalize, and explore weight issues.

Furthermore, participants suggested that doctors try to be more encouraging with their patients’ weight-management efforts, as well as work collaboratively as a team.

Among the suggestions regarding how doctors dialogue about weight-related issues with women, all of the participants highlighted the importance of having open, two-way conversations. Suggestions included talking to patients about why weight changes may have occurred, barriers to meeting their goals, and available resources. Participants communicated that if doctors made efforts to get to know their patients, the mutual trust
that would develop between them would promote higher quality visits and more comprehensive care.

Regarding recommendations for doctors within the open-dialogue realm, participants also suggested that doctors explore the specific contexts inherent to patients’ lives. Context included considering patients’ particular lifestyles, SES, ethnicity, stressors, barriers, mental health, relationship with food, and disordered eating or eating disorder backgrounds. Throughout their interviews, participants voiced the need for doctors to treat each patient as an individual, considering and respecting their lifestyles when formulating weight-management treatment goals and plans. In relation to resources and direction, participants communicated the desire to have doctors who were able to think creatively and openly in relation to their weight-management advice, as opposed to the generic prescription of “eat less and exercise more.” If weight was an issue, participants welcomed specific and concrete verbal or written information about weight-management advice, and also appreciated referrals when the weight-based support was out of the scope of the doctor’s knowledge base or practice. Participants communicated the imminent need for further training opportunities for doctors in weight-management care, as well as significant systemic changes in the medical system as a whole.

As can be seen from the various categories included in the core category of Practice, there is opportunity for developments in the medical community that could meaningfully transform the way in which women experience weight-related dialogues with their doctors. Participants’ recommendations to doctors provided a clear depiction of an empathetic and compassionate doctor, one that has clear and sensitive communication
skills, does not judge or shame, and works as a team within a supportive patient-centered approach.
CHAPTER SIX

DISCUSSION

“Handle with care, the body is a soft spot for everyone.”

Madeline

The purpose of this study was to explore experiences associated with weight-related dialogues between doctors and women from varied social strata. A critical feminist perspective was used to explore the broader dominant cultural and social processes that affect the ways in which these dialogues were received, and the meaning created from them. The investigation focused on the recollections of 18 women and their experiences with doctors while receiving weight-related feedback or information. Included in this study were women with or without current or former eating and/or weight-related struggles, as well as women who exhibited diversities in ethnocultural background, sexual orientation, socioeconomic status, and body size, ranging from underweight to obese. The women were aged between 18 and 45 years and were highly motivated to share their experiences, revealing a range of perceptions, beliefs, and values regarding their interactions with doctors, as well as a host of emotional, psychological, and behavioural responses. Beyond merely describing their complex reactions, they also shared valuable suggestions for doctors seeking to provide weight-related care for women in the future.

Throughout the inquiry, attention was paid to the following research questions: What were women’s experiences receiving weight-related information from their general practitioners? What did women highlight as positive or negative processes in the doctor-
patient interaction when receiving input regarding their weight? And lastly, what suggestions did the women have for doctors who discuss weight-based issues with their patients? In general, participants’ narratives demonstrated that women’s experiences receiving weight-related information or advice from their doctors were strained by a number of variables. These included factors such as power differentials and weight-based stereotypes regarding the size of women’s bodies. As such, the doctor-patient relationship emerged as an important positive dimension in the provision of weight-based care.

Furthermore, the acknowledgement of women’s lived contexts and histories proved to have implications in shaping how weight-related interventions were received. Based on their experiences, participants provided thoughtful recommendations for doctors’ weight-related practices that included important interactional skill sets, strategies to increase awareness of patients’ contexts as well as provide collaborative support, and the necessity of further training for doctors providing weight-based care for women.

The Discussion chapter is divided into three major sections: Women’s Experiences of Doctors’ Weight-Related Information: Key Findings in Relation to the Existing Body of Knowledge; Study Strengths, Limitations, and Areas for Future Research; and Clinical and Educational Implications.

**Women’s Experiences of Doctors’ Weight-Related Information: Key Findings in Relation to the Existing Body of Knowledge**

Three core categories emerged from the analysis of data culled from the transcribed narratives: Weight Weighing on the Doctor-Patient Relationship; Patients’ Self and Body Experiences; and Practice. The first core category, Weight Weighing on
the Doctor-Patient Relationship, revealed ways that weight-related dialogues disrupted or strengthened the doctor-patient relationship, depending on the language used, the method of delivery, discordance or congruence in assumptions about health and weight, and the perceived role of physicians in weight management.

In contrast with the first core category, which focused on the quality of the doctor-patient relationship, the second core category, Patients’ Self and Body Experiences, centred on women’s personal ongoing experiences with body size and weight in relation to cultural norms of appearance, weight stigmas, psychological issues, and physical illnesses. These experiences shaped women’s reactions to their doctors’ input regarding body weight and shape, and were therefore central to understanding the complexity of weight-related exchanges in the doctor-patient relationship. This was further illuminated by the powerful impact of doctors’ input on participants’ self- and body-esteem, confidence, and behavioural choices.

The third core category, Practice, revealed that doctors most often had a prescriptive approach to weight loss, devoid of consideration for their patients’ individual contexts and prior weight-related histories. Moreover, the women offered insightful recommendations regarding the ways in which doctors’ practices could be changed toward a constructive re-shaping of weight-related interactions and care.

The present study expands the existing psychological research on women and weight in the Canadian medical environment by providing a detailed and rich depiction of three central dimensions highlighting how weight and power relations interact with the doctor-patient relationship, the importance of context in shaping women’s experiences regarding weight-related interactions with doctors, and meaningful recommendations for
doctors providing weight-related care for women. To date, there are very few published accounts that investigate women’s experiences with doctors and weight dialogues in Canada.

Kirk et al. (2014) recently published a large-scale study in Canada that explored obesity management at three different levels, including individuals who self-identified as overweight, health care providers, and policy makers. With the aim of understanding how to provide adequate support for individuals involved with obesity management, Kirk et al. (2014) explored the underlying issues of how weight management is viewed across health care systems and society as a whole, concurrently gaining important perspectives from multiple stakeholders. In their qualitative study, Kirk et al. (2014) conducted semi-structured interviews with 22 individuals living with obesity in Eastern Canada, 16 interviews with health care providers, and four interviews with policy makers. Similar to the present investigation, the study by Kirk et al. (2014) was informed by a feminist perspective that examined the process of power and its expression in relation to gender, social status, ethnicity, culture, and health or ability. Three themes emerged from their analyses across all participant groups: Blame as a Devastating Relation of Power; Tensions in Obesity Management and Prevention; and the Prevailing Medical Management Discourse.

Similar to the 2014 study from Kirk et al., the present investigation has problematized the way issues of body weight are currently addressed in the Canadian health care system. It has also highlighted the complexity and challenges in weight-related care. By including perspectives of health care providers and policy makers, Kirk et al. (2014) had a broader lens through which to view these challenges. For example,
they incorporated an important discussion of tensions in obesity management in terms of systemic and political issues that permeate weight treatment, often leaving health care professionals and policy makers at a divide when it comes to the focus of obesity treatment (e.g., obesity management versus obesity prevention), as expressed in their theme of Tensions in Obesity Management and Prevention.

The findings of the present investigation were, in many ways, in line with the results from Kirk et al. (2014). Particularly, the ways in which weight issues disrupt doctor-patient relationships and, hence, the provision of health, have emerged as core themes in both studies. Both highlighted the adverse impact of blaming and shaming individuals seeking health care, and the challenge of finding appropriate weight-related care in a system unable to support them. Furthermore, findings demonstrated the adverse impact of the current medical discourse about obesity management and the related prescriptive practice of “eat less, exercise more,” delivered without consideration for context. While Kirk et al. (2014) described these barriers within their themes of Blame as a Devastating Relation of Power and The Prevailing Medical Management Discourse, in the present investigation these challenges were expressed in the core categories of Weight Weighing on the Doctor-Patient Relationship and Practice.

Appreciably complimentary in nature, these two studies have led to topical findings that can be used to bring awareness and direction towards addressing the provision of appropriate support for individuals receiving weight-related care in Canada. Albeit similar, the present study exhibited meaningful differences that provided a slightly different angle of inquiry, and subsequent findings. While exclusively utilizing the vantage point of women patients, the present investigation has addressed additional
issues. In particular, the present study invited participants to describe their reactions to their doctors’ weight-related commentaries within the context of their lives, and to reflect upon their values regarding weight and health in relation to that of their doctors. This was addressed in the core category of Patients’ Self and Body Experiences. This category expanded the understanding of the complexity of weight-related exchanges in the doctor-patient relationship, and the ways in which women’s ongoing lived experiences with body size and weight shape experiences and reactions to their doctors’ weight-related dialogues and care.

Another important dimension of the current study was its inclusion of individuals with a diversity of body weights ranging from underweight to obese, adding to practical implications for doctors in providing not only obesity management information, but also weight-management directives for individuals who present as underweight. The current study also highlighted positive factors in doctor-patient interactions, and the ways in which these positive experiences strengthened the important doctor-patient relationship. This is an area that tends to be neglected in the field of research on weight-related support in the medical community, and is an important element in showcasing evidence for what practices are working in this area of care, and to illuminate why these practices are effective. Lastly, with an additional and intentional focus on recommended modes of practice, participants in the present study were invited to share their reflections regarding suggestions for doctors offering weight-related care to women in the future. In doing so, specific clinical implications evolved, encompassing weight-management practices that can apply to doctors providing weight-based care for women of varied backgrounds and weights.
Merrill and Grassley (2008) provided another account of women’s experiences with weight and weight-related care. Congruent with the present study, Merrill and Grassley (2008) problematized how issues of body weight and health were addressed in the medical community. In their qualitative study consisting of eight women based out of West Texas, USA, they explored women’s experiences with health care services as overweight patients. Individuals were included in the study if they met the BMI criteria for overweight or obese (BMI ≥ 25). Comparable to the present study, as well as that of Kirk et al. (2014), Merrill and Grassley (2008) incorporated a feminist perspective as part of their methodological approach, grounding the research in women’s lived experiences. Four themes emerged from their analysis: Struggling to Fit In; Feeling not Quite Human; Being Dismissed; and Refusing to Give Up.

Exploring exclusively the lived experiences of patients who were overweight and obese, Merrill and Grassley (2008) highlighted the physical challenges of trying to fit into health care office spaces and environments due to their weight and size (i.e., single-chair seating, small examination tables), as well as experiences with requiring larger medical gowns and blood pressure cuffs. The researchers labelled the emergence of these challenges as Struggling to Fit In and demonstrated how these restrictions impacted the provision of care received by patients who were overweight or obese. Not unlike the current study, the doctor-patient relationship emerged as a central variable in weight-related care as well as women’s beliefs and predominant dissatisfaction regarding the ways in which issues of weight and health are currently addressed. Both studies illustrated the stigma of being different because of body size, as well as the constant battle regarding weight as the cause of all medical complaints, often involving demeaning
and shaming interactions with health care professionals. Where Merrill and Grassley (2008) described these challenges within their themes of Feeling not Quite Human and Being Dismissed, in the present investigation these experiences are expressed in the core category of Weight Weighing on the Doctor-Patient Relationship. Similarly, both studies showcased women’s ongoing struggles with weight and feelings of defeat by failed attempts to manage their weight. This particular issue was discussed in the theme Refusing to Give Up in the study by Merrill and Grassley (2008), and in the core category Patients’ Self and Body Experiences in the present study.

Despite the similarities between the present investigation and Merrill and Grassley’s (2008) study, there are also meaningful differences. For instance, the current study provided a more elaborate understanding of the context of women’s lives by focusing on their personal ongoing experiences with body size and weight in relation to cultural norms of appearance, weight stigmas, psychological issues, and physical illnesses, as demonstrated in the core category Patients’ Self and Body Experiences. By providing a more detailed depiction of women’s lived context, the current study demonstrates how context shapes women’s experiences and reactions to doctors’ weight-related dialogues. Furthermore, the present study shed light on the core category of Practice, revealing that doctors often had a narrow approach to weight management, and that women had important ideas for constructive changes that could substantially improve weight-related care between doctors and patients.

While Merrill and Grassley’s (2008) research has helped to elaborate on the experiences of women in health care environments, several other limitations existed, including a small group of exclusively Caucasian participants who were overweight or
obese and living in the urban core of Texas. The current study, on the other hand, explored such experiences from a number of different social strata by including women with or without current or former eating and/or weight-related struggles, as well as women of different ethnocultural backgrounds, sexual orientations, socioeconomic status, and body size and weight. Practical applications suggested by participants in the present investigation may therefore resonate with women of these different backgrounds, and may apply to doctors who see a diversity of patients.

Lastly, the present study looked specifically at general practitioners versus a range of health care professionals, allowing a more focused inquiry into this area of care. As previously stated, doctors, given their role in front-line care, often provide lifestyle counselling during yearly physical examinations (Lau et al., 2007). However, doctors often report feeling under-trained in this particular area of care (Bocquier et al., 2005) and many women report negative experiences in receiving weight-related interventions (Potter et al., 2001). By providing a focused inquiry on weight-related information delivered by doctors, the present study was able to examine what areas required strengthening within their practices, as well as how the recommended modes of practice specific to doctors’ interactions could improve weight-related care for women in the future. Furthermore, another benefit to focusing on doctors within the present study was the ability to explore the impact of power differentials between doctors and patients, and to understand more fully how said power differentials interact with the multifaceted meanings of weight and weight-management interventions within the sociocultural contexts in which they occur.
In general, there is a dearth of research pertaining to the experiences of weight-related dialogues between patients and doctors in relation to the Canadian culture and medical care system. This is especially true in light of the intersections of multiple social factors, including the influence of power and privilege, in shaping women’s experiences with doctors and weight. In order to better inform and support GPs, the present study detailed a holistic representation of women’s lived experiences, both inside and outside the medical environment. The use of a critical feminist perspective supported the present study in providing a detailed and rich depiction of women’s experiences as recipients of weight-related care from their doctors.

Given that there is a dearth of research exploring Canadian women’s experiences with weight-related care, as well as the influence of women’s lived contexts on the reception of weight-management interventions, this study expanded existing literature by offering a unique exploration into the complexity of weight-related exchanges in the doctor-patient relationship, and the ways in which women’s ongoing lived experiences with body size and weight shape their experiences and reactions to weight-based care. The following discussion has addressed, in greater detail, previous research on weight-related interventions in primary care, highlighting important parallels and discrepancies in relation to the present study.

**Weight Weighing on the Doctor-Patient Relationship**

Weight Weighing on the Doctor-Patient Relationship was the first core category to emerge from the women’s narratives, highlighting the doctor-patient relationship and the different dynamics involving weight that interacted with this important connection.
This core category, in a general sense, included participants’ experiences with power
differentials, a lack of exploration regarding important contextual variables within
participants’ lives, divergent views concerning assumptions about weight, health, and
roles in weight-related care, and weight-related advice that lacked meaning or practicality
for participants. The complexity and significance of the doctor-patient relationship in
weight-based care evolved as an overarching theme in the present study. Further, the
sensitivity related to the topic of weight was shown in numerous instances within the
women’s narratives during which they described weight-based dialogues evoking far
more emotionally charged experiences than other areas of medical care.

Specifically, the topic of weight proved multidimensional, revealing a powerful
impact on how care was received within the confidentiality of the doctor-patient
relationship. Importantly, the doctor-patient relationship is one that naturally involves
imbalanced power differentials, patient vulnerability, and the impending potential for
shame and blame (Ong et al., 1995). Narratives captured in Weight Weighing on the
Doctor-Patient Relationship displayed dynamics that worked to either strengthen or
rupture the doctor-patient relationship, thereby underscoring the meaningful clinical
implications for healthcare professionals working with women in this area of care. The
distinguishing quality of the current study was the use of a critical feminist lens that
worked to deepen our understanding of women’s relational experiences with their doctors
and the ways in which weight-based exchanges intersected with societal influences of
privilege, power, gender, ethnicity, and social status. The majority of the women in the
present study had experiences with multiple doctors and weight-based care; every
participant described at least one instance with a doctor where the doctor-patient relationship was ruptured due to weight-based matters.

For example, over half of the women interviewed discussed negative experiences related to receiving unsolicited weight advice from their doctors. A number of different contexts were emphasized in terms of receiving unsolicited advice including recommendations to lose weight, gain weight, and advice to “do more.” Participants’ discourses detailed emotional responses to unsolicited advice such as anger, shock, dismay, confusion, self-consciousness, and frustration. Several participants talked about how they felt their weight was unnecessarily problematized, and that their doctors lacked a comprehensive or holistic understanding of their health. Pointing to an additional factor that shaped the reception of weight-based advice was whether or not the advice was provided in the context of actual weight-related health issues such as diabetes, hypertension, and high cholesterol.

Many of the women interviewed discussed receiving unsolicited weight advice from their doctors based purely on direct observation of their bodies versus actual medical examinations indicating some form of “health problem.” Similarly, participants were dissatisfied when doctors brought forth weight as an issue even after their medical exams demonstrated that they were healthy. The present study expanded the existing literature by demonstrating that participants who were deemed underweight, overweight, and obese all discussed frustrations regarding unsolicited weight advice in the absence of tangible medical concerns. As was mentioned previously, the existing literature has focused on participants in the overweight range or above, based on BMI (e.g., Merrill & Grassley, 2008; Thomas et al., 2008; Wards et al., 2009).
Harmful responses to unsolicited advice have been found by other researchers, such as Amy et al. (2006), who described the negative effects that unsolicited weight advice can have on patients’ satisfaction with care and health-seeking behaviours. In their quantitative study exploring overweight and obese women’s experiences with weight-related care, close to half of participants (46%) reported negative experiences related to unsolicited advice that resulted in subsequent delays or avoidance of important medical appointments thereafter. Findings such as these raise important questions regarding the issue of doctors providing unsolicited weight-related advice to their patients, a practice that medical guidelines in Canada have, in fact, encouraged in the name of health (Lau et al., 2007).

Although the majority of women in the present study described receiving unsolicited advice in a negative way, some of the women talked about how they understood the need for doctors to broach the topic of weight, if in fact their weight was detrimental to their health. In these instances, participants’ dissatisfaction with unsolicited weight advice evolved more specifically, from the ways in which doctors delivered such advice. For instance, participants described how if their doctors had provided the unsolicited advice in a more positive way (e.g., warm, caring, sensitive), they would have received the information more favourably. Accordingly, the ways in which doctors delivered weight-related information or advice, including their mannerisms, tone, and body language, all proved to have a powerful impact on how participants accepted or received these weight-based messages, a finding that is also supported in the existing literature (e.g., Merrill & Grassley, 2008; Thomas et al., 2008; Ward et al., 2009).
Almost half of the participants in the present study described the delivery of weight-related advice as being demeaning, belittling, or condescending. Several of the participants questioned their doctors’ professionalism and the appropriateness of their weight-related care. Instances such as these helped illuminate the power differential between doctors and patients in an environment of authority and control that naturally affected the doctor-patient relationship. In support of these findings, Ward et al. (2009) highlighted the influence of the manner, timing, and tone of physicians’ communication styles on how messages were perceived. Notably, Ward et al. (2009) reported that the manner in which information was communicated was just as important as what was being said. The same pattern of results were found in the present study, whereby participants stated that if their doctors’ advice was conveyed with more respect and sensitivity, they would have received their suggestions in a more positive light.

Examples illuminating the influence of doctors’ non-verbal and verbal communication styles have been frequently demonstrated in the research literature (e.g., Merrill & Grassley, 2008; Packer, 1990; Ward et al., 2009). In line with existing research, the current study highlighted the importance participants placed on doctors providing respectful communication, conveying care and concern for their wellbeing, as well as providing interactions that were free of judgment. Both Ward et al. (2009) and the current study demonstrated the negative effects of disrespectful, judgmental, and blunt communication styles on one’s motivation for facilitating change. Moreover, doctors who practiced shaming and scolding techniques were deemed to be less effective in motivating behavioural change.

Although positive experiences with doctors in regards to weight-related
communication were fewer than negative experiences, those participants in the present study who highlighted good interactions with their doctors cited a number of qualities that supported or strengthened the doctor-patient relationship. For instance, three of the 18 participants talked about having extremely positive experiences related to the delivery of weight-related messages from at least one of the doctors they had seen. In turn, these participants explained how they felt cared for, validated, and were provided with a space to voice their feelings and concerns. Accordingly, these participants experienced a positive connection with their doctors and felt as though they were being treated like human beings. Previous research studies reinforced the impact of delivery on the quality of care received and the doctor-patient relationship. For example, Thomas et al. (2008) found that women whose doctors delivered weight-related information and advice in a sensitive, warm, and compassionate way reported positive experiences with weight-related care more often than women who’s doctors did not employ compassion or sensitivity.

Another dynamic that impacted the doctor-patient relationship in the present study related to what participants described as a loss of voice in the medical room. A number of participants talked about feeling dismissed by their doctors, or said that their views were not regarded as credible. This was clearly demonstrated in one participant’s narrative as she described the experience of feeling like she had lost all of her rights by being a “fat person,” and wondered if doctors would have nicer conversations with her if she were thin. Many of the participants talked about how their doctors did not believe them when they expressed the “health-promoting” behaviours they participated in, stating how their credibility quickly depreciated as their bodies fell outside the “acceptable” ranges of
weight. This again was seen in both underweight and overweight women. Specifically, participants talked about how they perceived this dismissiveness to be directly related to the weight or size of their bodies, which evidently had a negative impact on the doctor-patient relationship.

Munch (2008), through a qualitative study of women’s experiences with hyperemesis gravidarum, described both the psychological and physical consequences related to not being understood or believed. When doctors dismissed their patients’ experiences (i.e., indicated that the women either were overreacting or fabricating symptoms), results often revealed a diminished sense of self-confidence and self-esteem, confusion, anger, and delayed or avoided medical appointments, which in turn exacerbated health concerns. Although Munch (2008) provided a different angle of inquiry, together these results have demonstrated the significance of supporting and strengthening the doctor-patient relationship through respecting, understanding, and validating patients’ subjective realities.

Undoubtedly, one of the most powerful breaches of the doctor-patient relationship was when participants perceived any stigma, stereotypes, or prejudices about weight from their doctors. A number of studies, both quantitative (e.g., Adams et al., 1993; Foutaine et al., 1998; Olson et al., 1994) and qualitative (e.g., Merrill & Grassley, 2008; Rogge et al., 2004; Thomas et al., 2008) have documented an abundance of experiences with weight-based stigma and the impact of weightism within the medical community. Stereotypical labels held by many health care providers included laziness, overeaters, and low intelligence (Puhl et al., 2008). In the present study, all but three of the participants
perceived discussions with their doctors as enforcing negative stereotypes about women’s weight and body size and/or weight-based stigmas.

Supporting these findings, Thomas et al. (2008) and Rogge et al. (2004) demonstrated that almost all of the participants who were considered obese had experienced stigma and discrimination by health care professionals. Furthermore, in the study by Thomas et al. (2008), many participants talked about experiencing humiliating and derogatory comments from their health care professionals. Packer (1990) described similar findings in terms of participants experiencing inappropriate and unprofessional comments from doctors due to their weight. Researchers have further highlighted the impact of stigma and discrimination on an individual’s sense of self, including feelings of shame, blame, and defectiveness (Merrill & Grassley, 2008).

Contributing to the depiction of weight-based stigma in health care professionals, two of the participants in the present study described their doctors expressing their personal opinions on women’s bodies and how they should gain or lose weight to adhere more to feminine ideals of appearance. As one participant explained, doctors’ personal opinions revealed weight stigmas that were somehow deemed appropriate when disguised through lab coats and medical language. Across the span of body sizes and shapes, the present study demonstrated experiences involving weight-based stigma and stereotypes, which in turn affected the doctor-patient relationship. Similarly, Mold and Forbes’ (2013) findings from their synthesis of the literature regarding obese patients and health care experiences demonstrated that weight stigmatization negatively impacted the relationship between patients and health care professionals.
As was previously mentioned, attribution theory has been used to offer an understanding of weight prejudice and stigma (Musher-Eizenman et al., 2004). For instance, Puhl and Brownell (2001) have suggested that people discriminate against larger individuals based on the belief that weight is controllable, thus people are perceived to be responsible for their weight. Similarly, Bocquier et al. (2005) found that many doctors’ views of obesity were based on a model that placed the onus on the individual for being overweight or obese (i.e., behavioural factors such as physical activity or food regimens). It was noted that this view often conflicted with patients’ perception of obesity in that patients attributed more importance to weight factors over which they had little or no control (i.e., genetic factors, unemployment, hormones, and stress).

In a 2003 study by Foster et al. that examined the attitudes of 620 primary care physicians regarding their views on obesity and its treatment, physicians rated all behavioural variables including inactivity, overeating, and a high-fat diet as significantly more important than any other cause of obesity, including genetic factors. However, research has demonstrated that the cause of obesity is complex and encompasses biological, psychological, sociocultural, environmental, and economic variables that are intricately woven with an individual’s weight (Aronne et al., 2009).

Also consistent with the weight-based attribution theory, Kirk et al. (2014) acknowledged that blaming individuals for their weight evolves, in part, from commonly held stereotypes. As was previously mentioned, women in the present study also talked about situations whereby they felt blamed or shamed for their weight, and perceived these communications to reveal doctors’ weight-based stigma and stereotypes such as
overweight individuals lacking control or willpower, or underweight individuals exhibiting an eating disorder. A few participants who described experiences where they did not feel shamed by their doctor for their weight, felt as though their health was being treated, and not their “fat”—a factor that played a powerful role in strengthening the doctor-patient relationship. Both the present study and research conducted by Kirk et al. (2014) highlighted the complexity of weight issues and the multitude of factors that need to be considered to avoid the common language of blame. Frequently internalized by the recipients, blame permeated the discourse of participants in both studies, compounded by multiple attempts to manage their weight with frustratingly limited success.

As was previously mentioned, women in the present study deemed in their medical charts to be underweight, also experienced weight stigma that in turn ruptured the doctor-patient relationship. Research literature on the health and wellbeing of underweight Canadians, without the co-occurrence of an eating disorder, is scarce and further limited with regards to exploration of the impact of underweight bodies on the doctor-patient relationship. With regards to research on physicians’ views of individuals who are underweight, it has been documented that some professionals believe that health risks associated with being moderately underweight are equivalent to that of being considerably underweight as well as overweight or obese (Che, 2002). In part, this could explain the present study’s results whereby the participants who were deemed underweight talked about their doctors exhibiting unjust concern regarding the size of their bodies. Lack of exploration in relation to underweight women’s experiences with health care professionals could be due to the primary focus on the obesity epidemic and the associated health risks that emphasize weight-loss measures as a means to attain
Another area of weight-related care that demonstrated tensions between participants and doctors was the suitable access to support for weight-management practices and care. Participants in the present investigation described how doctors routinely focused on modified eating and exercise patterns. By centring on eating and exercise, doctors excluded medical, social, environmental, and cultural factors that may also influence weight (Aston et al., 2012). Further, such a narrow focus may lead to the largely unsuccessful outcome of such interventions (Lyznicki et al., 2001). The lack of appropriate and accessible weight-related support may speak to a larger systemic issue inherent within the medical environment (Kirk et al., 2014). The question could be posed as to whether doctors default to eating and exercise advice because these are tangible practices to provide. Further research may be necessary to explore ways in which doctors could consider some of the broader, more complex factors that may be harder to distil, yet still deserve attention and time within doctor-patient conversations related to weight.

A related message depicted in the present study was that it did not matter if participants were eating a reasonably healthy diet, or if they were exercising regularly, or even if their medical examinations came back healthy. The size of participants’ bodies appeared to matter more than these reported health behaviours. Commonly, if participants’ bodies did not fit into the acceptable weight range, the message from doctors was “you are not healthy.” Goodman (1995) aptly depicted a woman’s experience regarding her weight:
Forever measured and compared with other bodies, trapped in a world where only one size fits in, she is truly haunted by our society’s grand obsession. She nevertheless finds herself apologizing for her less-than-‘perfect’ figure. Whether she conforms or rebels, she will pay a price. (p. 12)

In the present investigation, based on the weight-related advice received, many participants made the inference that their doctors upheld the assumption that weight or body size correlated to one’s health. That is, if you exhibited a weight that was not within the “normal” range, you were considered unhealthy. This theme demonstrated the tendency within Western Societies to “medicalize” obesity; more specifically, to use weight or body size as a direct indicator of health. Many participants described extremely negative experiences whereby they felt judged unduly for ill health based on their weight or the size of their bodies. This view contrasted with participants’ beliefs on what health represented, with most participants viewing health as encompassing mind, body, and soul. Tensions between patients’ and doctors’ views on health proved to interfere with the doctor-patient relationship. Kirk et al. (2014) also highlighted differences in the perception of health between health professionals and overweight women.

Interestingly, research has suggested that some weight-related health concerns, such as elevated cholesterol and triglyceride levels, high blood pressure, and glucose intolerance, could be addressed and improved independently of weight reduction (Gaesser, 2003). The idea that improved health can occur independent of weight loss is important knowledge in light of the more recent documented risks associated with weight loss as a means of achieving health. Specifically, Rich and Evans (2005) demonstrated
how individuals who attempted weight loss to attain health may actually participate in extreme weight-loss measures that are counterproductive and even harmful to one’s health.

Findings from the present study generally indicated that primary care services lack the appropriate resources to effectively address participants’ weight-related issues, and thus, weight-based practices were often deemed useless or meaningless. Participants frequently felt that weight-related information was delivered in a rushed, ambiguous, and/or insensitive manner. In addition, participants reported that when the topic of weight management was broached, no explanation or correlation between weight and health was provided. These findings are in line with other studies within the existing literature (e.g., Mold & Forbes, 2013). For instance, Brown et al. (2006) detailed numerous accounts of participants’ describing their weight-related dialogues with their doctors as being insignificant or irrelevant. Similarly, Wadden et al. (2000) found that although participants were satisfied with their physicians’ care and attention to their general health issues, they were far less satisfied when it came to addressing issues of weight. In particular, they did not feel that their physicians offered much guidance for weight-management measures.

By interviewing physicians and policy makers, Kirk et al. (2014) were able to elucidate the systemic and political issues that permeate weight treatment, often leaving health care professionals and policy makers at a divide in terms of the focus of obesity treatment (e.g., obesity management versus obesity prevention). Further, Kirk et al. (2014) described the difficulties faced by individuals living with obesity when seeking support for weight-loss initiatives within the health care system due to a lack of
knowledge and resources on the part of doctors. The present study also demonstrated that the difficulties regarding weight-management interventions might also be, in part, due to the lack of exploration of participants’ contextual factors contributing to weight-based issues.

Overall, Weight Weighing on the Doctor-Patient Relationship begins to bridge the gap between women’s experiences with doctors’ weight-related care in relation to the Canadian culture and medical care system. Results from the current study confirmed and expanded the existing literature on women’s experiences with doctors’ weight-related care in participants exhibiting much diversity. In the present study, the processes that worked to either strengthen or weaken the doctor-patient relationship affected women across the weight spectrum in similar ways. These findings suggested that doctors may need further awareness and training regarding the manner in which they deliver weight-based care to patients of all weights and sizes. Even with the best intentions from doctors, weight-related practices may be perceived negatively, and even have detrimental effects on women, especially if women feel invalidated, marginalized or stigmatized in this process. Findings from the Weight Weighing on the Doctor-Patient Relationship core category highlight the importance of the doctor-patient relationship in the provision of weight-management interventions. This knowledge has important implications regarding informing and guiding GPs in understanding and navigating the complexities of providing sensitive weight-based care for women.
Patients’ Self and Body Experiences

The second core category that emerged from the current study shed light on participants’ lived experiences in relation to weight, and the ways in which these experiences shaped their responses to weight-related feedback received from their doctors. In particular, the study invited participants to describe their reactions to their doctors’ weight-related commentaries within the context of their lives, and to reflect upon their values regarding weight and health in relation to their doctors’ practices. All study participants described significant experiences with weight and body size that coloured the lens through which they viewed their doctors’ weight-related information and advice. In the existing literature pertaining to weight-management practices in medical care, patients’ histories and contexts are rarely explored in conjunction with doctors’ weight-based practices.

The results of the present study highlighted the importance of understanding participants’ lived experiences in the domain of weight and body size. For example, half of the participants described the impact of physical and/or mental health difficulties on their weight. A number of medical and psychological issues were discussed that interacted with weight either directly or indirectly. Overall, the women in the present study perceived these issues to be, in part, causal factors for weight gain, challenging their control over their weight. Participants often drew attention to frustrations and tensions experienced when their doctors failed to acknowledge and consider the influence of physical and psychological issues on weight and body size. In the few instances where doctors inquired about the presence and impact of both physical and mental health issues, participants felt as though they were taken seriously, and that a holistic representation of
their health was being considered. Naturally, participants’ satisfaction with the quality of care in these instances was substantially increased. These findings speak to important clinical implications for doctors regarding the significance of trusting that the time spent investing in comprehensively understanding their patients will go a long way towards strengthening the essential doctor-patient relationship and increasing the quality of care received.

Findings from both quantitative and qualitative studies supported the results of the present investigation, highlighting the intricacies of contributing factors in weight statuses (e.g., Magallares & Pais-Ribeiro, 2014; Merrill & Grassley, 2008; Rich & Evans, 2005; Thomas et al., 2008). For example, Thomas et al. (2008) carried out a qualitative study exploring the lived experiences of people who were obese. Participants described issues that interacted with weight including emotional and mental health issues, genetic factors and hormonal problems, and financial concerns. The researchers contended that participants’ voluntary life choices played only a small role in their body size and weight.

In relationship to psychological stressors, the present study also detailed the accounts of several participants regarding their struggles with emotional and stress-related food consumption. Participants discussed how they used food to comfort themselves in times of high stress or anxiety. Their narratives often contained feelings of guilt about “emotional eating.” Researchers have confirmed that eating is not always for satisfying physiological needs, but works to support an individual’s emotional needs as well (e.g., Antoniou, 2009; Dube, LeBel, & Lu, 2005; Macht & Simons, 2000). Lending support to some of these processes, participants in Antoniou’s (2009) qualitative dissertation exploring women’s life history experiences with food and eating, talked
about eating while under stress or anxiety as a means to regulate negative affect. Research by Dube et al. (2005) supported these findings, demonstrating that negative emotional states in women were often decreased by food consumption, followed by feelings of guilt. Similar to the participants in the present investigation, Antoniou (2009) found that women loosened their control over their eating during special occasions, or to reward themselves when they had exhibited a period of “good” eating behaviours. These findings indicated that emotional states needed to be considered when addressing issues of weight.

Another meaningful challenge present within participants’ narratives in the current study related to everyday experiences with weight-based stigma and discrimination. Similar to those experiences described within the medical environment, half of the participants in the present study expressed experiences of weight-based stigma and discrimination in the general community, capturing societal prejudices regarding weight. The women interviewed talked about being discriminated against in employment opportunities, and how they were exposed to stereotypical labels including unintelligent, disgusting, lazy, and uncontrolled. In line with findings from the current study, different researchers wrote about common labels associated with being overweight such as lazy, weak, undertrained desire, deviant, unmotivated, less competent, noncompliant, and sloppy (e.g., Bordo, 1993). Women deemed underweight in the present study were exposed to strangers continuously commenting on their weight, showing disgust for their size, or assuming the presence of eating disorders. The immense impact of stigma and discrimination on the self and body experiences of participants, including self-esteem and self-worth, were captured in these narratives.
As previously reviewed, weight-based stigma and discrimination in the general population have been well documented in the research literature (e.g., Bordo, 1993; Carr & Friedman, 2005; Klaczynski et al., 2009; O’Brien et al., 2007; Puhl et al., 2008; Puhl & Heuer, 2009; Roehling, 1999; Thomas et al., 2008). Researchers have suggested that because of the highly visible nature of weight, individuals who are overweight or obese are subject to multiple forms of prejudice, negative attitudes, and discrimination (Puhl & Heuer, 2009). Research has demonstrated that individuals who are obese are six times more likely to report weight discrimination (Puhl et al., 2008). Thomas et al. (2008) reported that all but four of their 90 participants had experiences with stigma and discrimination, including being refused or fired from a job due to their weight, as well as having strangers comment on their weight with underlying tones of blame and shame. The four participants who did not share these experiences were male. Studies have documented the psychological consequences of weight-related stigma, including lowered self-esteem and self-worth (Puhl et al., 2008; Rogge et al., 2004). Rogge et al. (2004) further highlighted the overwhelming sense of powerlessness and humiliation that larger individuals feel as a result of weight-based stigma in their lives.

Participants’ narratives demonstrated prominent issues relating to their lived experiences within prescribed sociocultural ideals regarding women’s weight and body size, which idealize only a very narrow and often unattainable range of acceptable weights. Considering the existing social atmosphere that idealizes thinness as an essential feminine quality (Goodman, 1995), and the ensuing internalization of this ideal by many women, it is not surprising that participants in this study spoke about feeling the pressure to attain thinner bodies. These pressures were not only seen within the attainment of
cultural aesthetic appeals, but also in the achievement of a “healthy” status. All of the women interviewed talked about how the media sells an image of health, and utilizes this image to instill fear and a sense of urgency to conform to unrealistic body sizes in the name of good health. Many participants talked about the constant tug-of-war between following their personal idea of health versus participating in unhealthy diet regimens to attain a body endorsed by popular culture and the medical system alike.

These findings are in agreement with studies illuminating Western culture’s widespread messages associating thinness with health (e.g., Burns & Gavey, 2004; Goodman, 1995; Rich & Evans, 2005). As previously reviewed, researchers in the obesity discourse have documented the strong emphasis on weight loss and thinness as a means to achieve health (Campos, 2004), which has been expanded upon in popular culture’s portrayal of health and beauty (Rich & Evans, 2005). Weight-loss industries have capitalized on weight and health messages by offering “quick fixes” to attain thinness and health (Goodman, 1995). This is in line with participants’ experiences of powerful messages portrayed by the media, encompassing prominent weight-loss discourses that proliferate consumers’ minds (Wann, 2009). Similar to the current findings, researchers have demonstrated the dangers associated with health messages depicted by popular culture involving both psychological and physical consequences pursuant to attaining health via an impractical and unfeasible ideal of thinness (Fraser, 2009).

In the current study, four of the participants exhibited protective factors shielding them from internalizing dominant societal norms. In particular, participant talked about shifting their concentration from appearance-based evaluation and comparison to a more
felt sense of overall wellbeing by focusing on what was meaningful to them. In accordance with the current findings, Thomas et al. (2008) discussed a number of strategies women used to combat mainstream pressures. Strategies included switching off, ignoring weight-related messages, or using humour, which in turn had a positive influence on their psychological wellbeing. Together these findings suggest that doctors may be able to better support their patients by encouraging them to critically disengage from the pressures of mainstream messages as a means to improve health. This could be achieved by shifting the focus from a weight-based evaluation of health to more of an overall evaluation of one’s wellbeing similar to that supported in the Health at Every Size (HAES) movement (Robison et al., 2007).

Alongside the many weight-related struggles, ethnocultural differences and cultural transitions were similarly shown to, at times, accentuate the difficulties in attaining a body weight that was considered healthy. Differences were demonstrated in the types of foods consumed as well as the meaning behind what food represents. Further, many participants described how their familial and cultural values and traditions regarding food, learned during childhood, transferred into their adult lives, often creating challenges in attaining their goal weights. Several participants from Asia, for example, described how food in their culture was a way they joined together and expressed love. Lending support to some of these processes, Antoniou’s (2009) qualitative research revealed the influence of family socialization on such values. Antoniou described how the socialization of food values encompassed “learning social rules, learning obedience, learning about food and desire, and learning to cope with emotions” (p. 215).
As can be seen, a number of diverse sociocultural factors influence and interact with how women of different shapes and sizes carry themselves through their everyday lives. Most participants in the study whose bodies did not fall within the “acceptable” weight range experienced judgement and blame from others. This fuelled participants’ desires to alter the way their bodies appeared. All of the women interviewed talked about weight struggles at one time or another in their lives. In relation to weight-loss attempts, participants described numerous strategies to lose weight including: portion control; counting calories and caloric restriction; cutting out desserts, carbohydrates, or fatty foods; running and walking; and joining weight-loss support groups such as Dr. Bernstein Diet and Health Clinics and Weight Watchers. Prevalent throughout the weight-loss narratives were the negative consequences associated with behaviours such as dieting. These included extreme weight fluctuations and mental exhaustion from trying to attain a specific weight, as well as financial burdens related to different weight-loss measures.

Research from the existing literature supports findings in the present study regarding the challenges associated with weight-loss practices, especially among women (Antoniou, 2009; French et al., 1999; Goodman, 1995; Touster, 2000). For instance, in research conducted by French et al. (1999), women used a number of commonly prescribed weight-control behaviours including exercise, calorie restriction, portion control, and avoidance of particular foods. These results are further supported in Antoniou’s (2009) study, which documented parallel weight-management measures and highlighted the motivations behind weight control, including fear of increasing in weight or becoming fat.
Many participants in the current study partook in weight-loss measures in order to attain a socially desirable image of health. Researchers have suggested that the search for wellness has even proliferated moral discourses, whereby today’s society constructs a moral world of *good, bad,* and *should* regarding health activities and particular lifestyle routines (Conrad, 1994). Lupton (1995) argued that the medicalization of obesity, wherein being obese is equated to being unhealthy, fuels the current cultural values regarding the preservation of health and evading illness as a personal and moral responsibility. Similarly, Antoniou (2009) demonstrated that participants’ engagement in weight-control activities reflects an aspiration to be perceived in a socially acceptable manner. The desire to change or alter their bodies, coupled with body dissatisfaction and body consciousness, was present in the current study in all but three of the participants’ discourses. The three participants who did not share this experience were the same participants who were able to critically detach from mainstream messages regarding the thin ideal and the belief that being thin equates to having good health.

Similar to Goodman’s (1995) depiction of the social environment that overweight women must endure, participants’ narratives in the present study also revealed the feeling that their weight or weight-related behaviours were under surveillance, either by others (e.g., strangers, family, or health care professionals) or internally prescribed. The feeling of shame, regardless of where the surveillance originated from, was a common manifestation throughout this theme. Shame was also shown in participants who demonstrated body dissatisfaction. Researchers have found that the pressures for thinness are a significant predictor of body dissatisfaction, and that the internalization of this ideal helps fuel body dissatisfaction (Griffiths et al., 2000). Considering the ongoing
challenges with their body shape and size, it is imperative that health care professionals take into consideration the lived experiences of the patients they are treating and work toward providing not only a comprehensive approach in their weight-loss care, but also an approach that is attuned to women’s ongoing struggles.

Indeed, the study revealed how doctors’ words regarding weight and body size had a powerful impact not only on the doctor-patient interaction but also on the individuals’ felt sense of self. Clearly, weight-based care evoked far more emotional experiences than other areas of care. When participants’ lived contexts and histories were not explored, or when the delivery of care was deemed poor, a wide range of emotional, cognitive, and behavioural responses in relation to weight-related dialogues were documented. Specifically, doctor-patient interactions evoked numerous emotional reactions including anger, frustration, embarrassment, shame, discomfort, shock, and betrayal. Many participants remarked that they simply had not been treated well, and that their experience was not okay. In the words of one participant, “I felt like a specimen.” Indeed, the research literature has similarly documented significant patient dissatisfaction with weight-related care (Amy et al., 2006; Brown et al., 2006; Kirk et al., 2014; Merrill & Grassley, 2008; Mold & Forbes, 2013; Thomas et al., 2008).

Although positive emotions with regards to weight-based care were exhibited far less frequently than negative emotions, three participants in the current study did find doctors with whom they had experienced positive interactions. These participants talked about feeling comfortable, validated, and understood. Aspects that contributed to positive experiences included feeling as though the doctor had a holistic picture of their health, took their medical concerns seriously, did not blame every ailment on their weight, and
addressed weight issues with sensitivity. The results of the present study were in concert with other research that documented positive experiences with doctors and medical care. In a number of studies, research participants described having positive interactions when their doctors spent quality time talking to them about their overall health and wellbeing (e.g., Merrill & Grassley, 2008; Ong et al., 1995; Wadden et al., 2000).

In the present investigation, behavioural reactions to weight-related dialogues with doctors were more varied than emotional responses. Interestingly, a few of the participants discussed feeling motivated to implement the weight-related advice prescribed by their doctors, even though their dialogues had not been particularly positive. Within these narratives, it appeared that participants placed more importance on the advice of their doctors than other participants who were not as motivated to implement their doctors’ behavioural recommendations. Half of the participants felt no motivation to implement weight advice. One participant in particular ascribed her lack of motivation as not having the “willpower” to make said changes. Other participants attributed the lack of motivation, in part, to not receiving enough direction or information on how to make the recommended changes. Additionally, half of the participants did not return to their doctors’ care due to the significant rupture they felt within the doctor-patient relationship. And finally, several participants experienced trepidation in seeking future medical consultations.

The majority of research to date on patients’ behavioural reactions to doctors’ weight-related advice has focused on avoidance of health care services, which can pose significant risks for subsequent health complications (Adams et al., 1993; Fontaine et al., 1998; Merrill & Grassley, 2008; Olson et al., 1994). In their quantitative study
investigating delays in treatment seeking behaviours, Amy et al. (2006) described that close to half of patients delayed or avoided medical support due to disrespectful treatment (36%) and negative attitudes (35%) from health care providers, as well as unsolicited advice (46%) about weight loss. Those patients who postponed medical care were significantly less likely to have important medical screenings such as Pap tests and timely pelvic exams or mammograms.

Mold and Forbes (2013) provided further support regarding the compounding effects of negative doctor-patient interactions and patients’ subsequent avoidance of engaging in health-promoting behaviours. In the present study, the most impactful experience influencing participants’ avoidance or reluctance in seeking further health care services was feeling disrespected, belittled, dehumanized, and misunderstood by their doctors. Brownell et al. (2005) contended that health care avoidance is often due to negative responses evoked by the experience of weight-based stigma and bias in health care. The researchers suggested that in order to break this cycle, health care providers must invest time in treating patients with respect, compassion, and empathy. Other researchers have suggested that the behavioural avoidance cycle is due to a combination of negative experiences with medical professionals, coupled with patients’ negative self-image and self-consciousness (Adams et al., 1993; Amy et al., 2006; Olson et al., 1994).

Participants in the present investigation described in great detail experiences when they felt invalidated and dehumanized by their doctors. These experiences were particularly poignant when their doctors discounted past weight-control efforts and informed them that they needed to do more. Many of the participants described how validation went a long way in terms of motivating positive changes versus feeling
deflated, defeated, and unmotivated. They talked about how doctors, of all people, should know just how challenging weight loss could be. A number of participants described how they felt like their fat was being treated, versus a holistic representation of their health. These dehumanizing experiences had a powerful influence on the doctor-patient interaction and the quality of care received.

Findings in the existing literature regarding doctor-patient interactions strongly supported results from the present study (e.g., Brown et al., 2006; Merrill & Grassley, 2008; Rich & Evans, 2005; Thomas et al., 2008; Ward et al., 2009). Dehumanizing experiences as well as demeaning and embarrassing interactions with health care providers were demonstrated in Merrill and Grassley’s (2008) study. Parallel to the current investigation, results illuminated many dismissive, depreciating, and embarrassing interactions with health care providers in relation to weight-related care. Participants voiced feeling “not quite human” in their interactions with medical professionals, which often involved weight-based stigma related to being of a different body size. In Merrill and Grassley’s (2008) study, participants used phrases such as “I am a real person,” and “I am more than my weight” (p. 142).

Participants in the current study described having strong reactions to weight labels including the “obese” and “obesity” labels. In line with these findings, Ward et al. (2009) described how their research participants disliked the word obese, used by their physicians, preferring more neutral terms such as “weight” or “excess weight.” Participants in the present study talked about how the word obese was associated with negative connotations and weight-based stereotypes. One participant described how the word obese paints a picture of someone who eats all day long, is lazy, and incompetent.
Similarly, Thomas et al. (2008), who explored individuals’ experiences with obesity, also found that participants disliked the obese label, and stated that this particular label amplified society’s disdain of larger individuals, describing it as a loaded word that evoked negative stereotypes and discrimination from others.

Participants in the present study talked about a number of experiences where their doctors’ weight-related discourses powerfully affected how they felt about their bodies and overall sense of self. These findings are important in relation to how doctors work with weight-based care in the medical community. Over half of the women interviewed described the negative impact that the weight-related interaction had on their self-esteem and self-confidence, invoking feelings of unattractiveness and a lack of comfort living within their bodies. As one participant shared, “I just remember it made my body less comfortable to live in for a while.” A number of studies have assessed the impact of such things as body dissatisfaction and low self-esteem on weight-related behaviours.

Importantly, research has demonstrated that body dissatisfaction, low self-esteem, dieting, and personal weight concerns were risk factors for developing disordered eating patterns or eating disorders (Darby et al., 2007; Downs et al., 2001; Irving & Neumark-Sztainer, 2002; Neumark-Sztainer et al., 2007; Urquhart & Mihalynuk, 2011). Unfortunately, in many obesity programs, there is an assumption that it is appropriate to be dissatisfied with one’s body size (Urquhart & Mihalynuk, 2011). Irving and Neumark-Sztainer (2002) described how body dissatisfaction was viewed as a motivational factor in weight-loss behaviours in the obesity literature.

Conversely, in the research related to eating disorders, body dissatisfaction had not only been cited as a risk factor for disordered eating, but also for negative
psychosocial consequences such as depression, anxiety, and poor self-esteem (Cash & Fleming 2002; Neumark-Sztainer et al., 2006; Powell & Hendricks, 1999; Stice, 2002). It is therefore disconcerting that over half of the participants in the present investigation talked about experiencing increased feelings of body dissatisfaction and decreased self-esteem and self-confidence during or after their weight-related interactions with their doctors. Myers and Rosen (1999), in their quantitative study demonstrated that body dissatisfaction and negative body image was correlated with exposure to weight-based stigmatization. They therefore suggested that medical professionals could positively influence patient experiences with weight by addressing any weight-based stigmas they may hold.

The present study expands the existing literature by affording an in-depth look into the ways in which women’s ongoing lived experiences with body size and weight influence how weight-related care is understood and experienced within the doctor-patient relationship. More importantly, the findings convey the challenges for the women in inhabiting their bodies under a cultural lens that objectifies women’s bodies and idealizes only a very narrow and often unattainable range of acceptable weights. Within this context, the words used by doctors regarding weight and shape have a powerful impact on the doctor-patient interaction, relationship, and individual felt sense of self. The current study has clinical implications in highlighting the importance of incorporating patients’ lived contexts and histories into weight-related care as they were demonstrated to play an intricate role in shaping experiences both inside and outside the medical environment.
Practice

The third core category that emerged from the present study focused on doctors’ weight-related practices received by participants, as well as participants’ thoughtful insights about ways in which doctors’ practices could be transformed, moving toward a constructive re-shaping of weight-based care. Participants’ narratives revealed that most often doctors had a prescriptive approach to weight loss, devoid of consideration for their patients’ life contexts or of their prior weight-related histories. In contrast, the women desired to have their health concerns treated in a holistic manner, as well as be afforded with care that encompassed respect, compassion, and understanding.

Participants’ narratives demonstrated the frequency of prescribed weight-management advice that included either physical activity or diet modifications. Several participants also discussed how their doctors recommended for them, based on their height, an ideal weight bracket for which to strive. The recommended advice from doctors in relation to both diet and physical activity varied in the amount of detail provided as well as the individualization of the advice given. For example, some participants received the suggestion that diet, exercise, or both were in need of modification. Most participants who received exercise or diet recommendations were simply encouraged to increase their level of physical activity and decrease their caloric input. Conversely, participants who were identified as underweight by their doctors were often instructed to decrease their physical activity levels and increase their caloric input. The majority of the time, however, participants were at a loss with regards to implementing such advice.
This prescriptive approach to weight-loss strategies has been described and problematized by a number of researchers (e.g., Beaudoin et al., 2001; Phelan et al., 2009; Tan et al., 2006). Challenges regarding a prescriptive approach to weight-management information related to the lack of consideration for genetic, medical, psychological, or sociocultural issues that contribute to weight. Heintze et al. (2010), in their qualitative study, found that dietary advice and increased physical activity were the two most frequently prescribed weight-loss methods suggested by doctors. Also congruent with the current study, weight-loss advice was given without consideration of the complex factors that influenced patients’ weight, as well as strategies to implement weight-control behaviours.

Quantitative research by Kirk et al. (2012) provided a more detailed picture of the weight-based support Canadians received from family physicians in relation to obesity concerns. Results demonstrated that 30% of participants had been advised by their doctors to lose weight without soliciting such feedback. Weight-loss advice was provided most frequently to patients who had a BMI of 27 plus with comorbidities. The researchers documented that of the 383 patients who were overweight or obese and had asked for weight-loss support from their physician, 4% reported receiving no advice, 68% obtained advice related to diet, 62% reported receiving exercise advice, 12% were instructed to access support through a weight-loss programs, and lastly, 4% were provided anti-obesity medication prescriptions.

Interestingly, qualitative research conducted by Brown et al. (2006) revealed four levels of obesity-management support received by participants from health care professionals. Level one consisted of health care professionals repeatedly indicating that
weight was a problem; however, they provided no direction on how to address the
problem. Congruent with the current study, this level demonstrated the highest participant
dissatisfaction, especially when weight was problematized and followed up with no
practical support and recommendations. Level two consisted of health care professionals
providing the minimum amount of support coupled with some practical suggestions,
often in the form of diet handouts. Once again, a number of participants found this level
of support to be dismissive and felt “brushed off.” Because this level of support was not
particularly helpful, patient satisfaction with the quality of care received was low.

The third level typology showcased health care professionals providing weight-
related support over a longer period of time. In line with the present study, patient
satisfaction was high when prolonged support encompassed non-judgmental,
psychological support and helpful advice on how to attain weight-based goals.
Interestingly, in this third level, participants still felt frustration similar to that seen in the
other levels of care, when weight-related advice was void of practical advice; however,
overall patient satisfaction was higher than in the first two levels.

Level four, as exhibited in the research by Brown et al. (2006), was identified as
the most rigorous and intensive level of support. Within this interval, health care
professionals were seen providing long-term, non-judgmental, and sensitive care that was
individualized and encompassed explanations and practical advice. Furthermore, this
level of care consisted of psychological support and referrals if required. Not
surprisingly, support at this level generated the most satisfaction in patients; however,
only four of the participants in the study by Brown et al. (2006) received this type of care.
The majority of participants described receiving advice at level one or level two of
support, which fuelled patient dissatisfaction regarding the medical system’s approach to weight-related care.

The findings from Brown et al. (2006) were consistent with results from the present study. Specifically, the three participants who talked about positive weight-related care had doctors who were willing to explore with them weight-management activities that were realistic and enjoyable, and that could be easily implemented into their lives. In these circumstances, participants who received more specific advice expressed appreciation and gratitude toward their doctors for making the effort to individualize their weight-management recommendations. Positive experiences were also highlighted when participants felt that their doctors provided them with non-judgmental environments, as well as offered more time and attentiveness within their visits. Throughout the study, all of the participants communicated their views and beliefs that the medical system required important structural changes to better support doctors in providing effective weight-related care.

Participants in the current study were invited to reflect upon their experiences with receiving weight-related care from their doctors in light of their lived contexts and histories in relation to weight. In doing so, the present study afforded participants a valuable opportunity to carry this conversation forward and make suggestions for doctors providing weight-related care to women in the future. Overall, participants most often focused on doctors’ interactional and relational skill sets, and on the need for doctors to consider the contexts and histories of their patients in care. In terms of the importance of quality of human dialogues, participants described their wish for interactions that were non-judgmental, empathetic, and sensitive, thus cultivating a comfortable environment to
openly discuss, normalize, and explore weight issues. Many of the participants talked about how simply changing the delivery and tone of the information and advice doctors were providing would make a tremendous difference in how this information was received. More specifically, participants suggested that doctors be mindful and considerate regarding the extreme sensitivity of the issue of weight for women, regardless of where one falls on the weight spectrum, and approach these weight-related conversations with professionalism, warmth, and care.

Qualities such as these were not uncommonly quoted in the research literature exploring what patients would like from their doctors with respect to weight-related care (e.g., Brown et al., 2006; Heintze et al., 2011; Merrill & Grassley, 2008; Ward et al., 2009). In their qualitative study exploring African Americans’ perceptions of the physician’s role in obesity management, Ward et al. (2009) highlighted the importance of quality communication when dialoguing with patients about weight. Specifically, the researchers drew attention to the important role that having respectful and positive communications played in the facilitation of behavioural change. Similar results were found in a qualitative study conducted by Heintze et al. (2011), which explored patients’ and physicians’ visions for weight-management practices for overweight and obese individuals. In their study both patients and doctors highlighted the power of positive patient-centred communication, encompassing empathy, neutrality, respect. Importantly, patients referenced the benefit of building trust within the doctor-patient relationship prior to weight being presented as an issue.

Anderson and Wadden (2004) also demonstrated how physicians’ negative behaviours and mannerisms (e.g., shaming, judging, and reprimanding) were harmful to
patients. Conversely, these researchers described how positive ways of being with patients (e.g., exhibiting warmth, compassion, or empathy) could strengthen the bond between patients and doctors, as well as allow for more meaningful interactions and treatment options for patients in weight-based care. These findings highlighted the importance of building and strengthening the doctor-patient relationship in order to develop an effective partnership conducive to sharing, exploring, strategizing, and implementing health-orientated changes.

Participants in the present study voiced the importance of feeling that their individual contexts and life histories were being heard and incorporated into treatment practices. Without inquiry into context, participants felt as though the barriers and challenges they faced with regards to implementing weight-management practices were not acknowledged or accounted for by their doctors. Aston et al. (2012) outlined how in the medical community, and in society as a whole, obesity is often treated as a lifestyle decision, which results in individuals being blamed, misunderstood, and marginalized. It is possible that if doctors embrace this viewpoint regarding weight, they may not feel the need to inquire about patients’ lifestyles, since they believe to already know the cause of the problem.

These findings are supported by other studies exploring patients’ suggestions for weight-related care. For instance, in accordance with the present findings, a number of researchers have highlighted the importance of having physicians dedicate time and attention to discussions that include accounts of patients’ lifestyles as well as readiness to implement weight-motivated changes (e.g., Ward et al., 2009). Walseth et al. (2011), having explored patients’ experiences with general practice and lifestyle counselling,
demonstrated similar findings to the current study regarding patient needs in weight-loss care. Out of the 12 Norwegian patients interviewed, participants described how their GP should be informants of medical information related to weight and health, as well as actively discuss the contexts of patients’ lives, including barriers and motivators in meeting the prescribed weight-related recommendation.

While previous studies have highlighted the importance patients place on having their mental health explored and incorporated into weight-loss prescriptions, unique to this study is the suggestion from participants that doctors be mindful of eating disorders and disordered eating backgrounds as well as weight preoccupations in their patients. For instance, several participants in the current study talked about their past struggles with eating disorders and touched upon their need for doctors to remain sensitive to how this may impact issues surrounding food and weight. This point confirms important clinical implications for doctors working in the area of weight-related care, especially in light of the eating disorder literature provided previously (e.g., Irving & Neumark-Sztainer, 2002). In particular, the 2006 Canadian Clinical Practice Guidelines advised doctors to screen and assess for eating and mood disorders (Lau et al., 2007). By asking questions regarding patients’ histories in terms of eating disorders, disordered eating, or weight preoccupation, doctors can be cognizant of any eating- or weight-based issues that may be exacerbated by traditional weight-management plans.

Participants in the current study discussed how every person has a unique relationship with food and weight, and thus it is imperative that doctors ask initial background questions pertaining to any food- or weight-related issues. This was certainly highlighted in one participant’s narrative as she talked about her struggles with an eating
disorder in relation to receiving weight-based care. In her narrative, she described how her doctor had complemented her thinner body size prior to becoming aware that the participant’s weight loss was fuelled by an eating disorder. This was particularly impactful on the woman’s road to recovery, as everything her doctor said about her need to gain weight was dismissed on the basis of the doctor’s previous compliment. For several of the participants, it was important to share in their narratives the idea that they were not blaming doctors per se, but instead illuminates how well-intentioned interactions can have the potential for negative consequences, influencing how patients and doctors collaboratively move forward. By bringing awareness to sensitive issues such as these, doctors can be better informed of the intricacies surrounding weight-related care.

Many of the participants in the current study discussed their belief that doctors could be effective facilitators of change within the weight-management realm. In particular, participants communicated that if doctors could work toward creating a safe environment, free of judgment and shame, as well as collaborate with patients, working as a team, that this could in turn, positively facilitate growth and behavioural change for patients desiring to lose weight. Researchers have supported the idea that doctors can, in fact, enhance positive motivation for weight-loss behaviours in their patients (Loureiro & Nayga, 2006). For instance, Tan et al. (2006) demonstrated that 78% of their participants felt that their GP could play an intricate role in motivating health promoting behaviours. Researchers such as Wadden et al. (2000) have suggested that by initiating discussions of weight in an empathetic, validating, and respectful way, patients would feel more encouraged to implement prescribed lifestyle changes.
Aston et al. (2012) noted that the language used to dialogue about weight concerns in primary care is laden with potentially adverse values and beliefs that can lead to discomfort, shame, or embarrassment. Similarly, participants in the current study suggested that doctors provide an environment that normalizes and validates patients’ concerns, as well as offer acknowledgement and encouragement for steps made toward their prescribed weight goals. As one participant in the current study remarked, “a little bit of encouragement could go a long way.” As Walseth et al. (2011) exemplified, by counteracting shame and vulnerability, patients may feel more comfortable seeking support from their doctors and working together as a team.

Another accompanying suggestion made by participants in the current study related to doctors spending more time learning about what their patients believed contributed to their weight status. Researchers have demonstrated that collaborating with patients to include their own ideas and reasoning behind their weight has been shown to facilitate weight-related modifications (Huang et al., 2004). Heintze et al. (2010), who conducted a qualitative study on physicians’ and patients’ views regarding preventative counselling for obesity confirmed that patient-centred care, including the assimilation of a patient’s views and attitudes towards weight management, were valuable components involved in improving the quality of care received. Further findings by Heintze et al. (2010) demonstrated that by taking a dialogical approach, positive improvements were seen in the doctor-patient relationship, which in turn strengthened the intervention efficacy.

Taken together, these are important findings that highlight the significance of doctors taking into consideration their patients’ points of view in this area of care. As was
previously discussed, research has demonstrated that the views of both patients and doctors regarding the causation of obesity are often in discord (e.g., biomedical causes vs. behaviour-based causes). In light of this knowledge, it seems unlikely that weight-loss strategies could be successful without first understanding patients’ values and beliefs regarding their weight. Participants in the current study explained that by delineating patients’ understanding of their weight, weight-management strategies could subsequently be personalized for their individual life contexts.

Along these lines, participants in the present study suggested that doctors work together with their patients in developing informed plans to address the issue of weight. Common to the existing literature is the fact that patients would like weight-management interventions delivered in a personalized, practical, and supportive way (e.g., Thomas et al., 2008; Walseth et al., 2011; Ward et al., 2009). Throughout their interviews, participants in the current study voiced their needs as patients to be treated as individuals with different lifestyle considerations, and therefore different needs regarding treatment goals and plans. By treating patients as individuals, participants commonly shared how they would feel more confident in their doctors’ sincerity while attending to their personal needs and treatment recommendations. Congruently, participants in a study by Walseth et al. (2011) spoke to the importance of doctors spending time in dialogue with patients and formulating personalized treatment plans that addressed patients’ unique weight-loss barriers and needs.

Many participants in the current study discussed desiring doctors who were able to think outside the box, as well as have the knowledge and openness to be innovative in their responses regarding weight-management interventions. Participants hoped that
creativity with weight-based measures may help in decreasing the generic “eat less, exercise more” practices that were often deemed unhelpful. Furthermore, they recommended that doctors provide patients with a medical explanation regarding health risks associated with a particular weight, as well as outline what weight loss (or weight gain) would do toward improving their health. Participants described how this type of information would facilitate motivation to follow prescribed weight-based suggestions, as patients would be better informed as to why they were following such advice. If weight was in fact a health issue, participants welcomed specific and concrete verbal or written information regarding weight management, and also appreciated referrals when the weight-based support was out of the scope of the doctor’s knowledge base or practice.

In support of these findings, researchers have demonstrated that patients would like doctors to be both a source of information and a caretaker (e.g., Walseth et al., 2011). For instance, Potter et al. (2001) recounted their participants’ preference for explicit direction regarding nutrition and diet plans, physical activity, and weight-loss goals. A common theme within the research literature related to the desire patients expressed for being provided with less ambiguous and more personalized information in terms of weight-loss strategies and goals (e.g., Heintze et al., 2011; Ward et al., 2009; Walseth et al., 2011). Participants in the present study acknowledged that access to practical information was one of the most important aspects of weight-related care.

Unfortunately, as it currently stands, many doctors have described feeling uninformed about how to address weight-management practices in relation to patients who are overweight or obese (Brown et al., 2006). For instance, Bocquier et al. (2005) demonstrated that 80% of GPs acknowledge the necessity of better training regarding the
management of their overweight or obese patients. Participants in the present study highlighted the systemic challenges that doctors face within the medical system. Over half the participants discussed the need for fundamental changes within the medical education system, to train doctors in providing more patient-centred care—specifically addressing the need for increased training in empathy, compassion, and sensitivity toward the emotional wellbeing of patients. Furthermore, participants suggested that educational curriculum incorporate specific training for doctors in effective weight-management practices. Studies in the existing literature have echoed participants’ recommendations related to the need for important systemic changes within the medical system, ones that support doctors in providing more sensitive patient-centred weight-based care (e.g., Brown et al., 2006; Kirk et al., 2014; Malterud & Tonstad, 2009).

As outlined by the participants in the current study, there is opportunity for developments within the medical community that could meaningfully transform the ways in which women experience weight-related dialogues with their doctors. Participants’ recommendations provided a clear depiction of an empathetic and compassionate doctor, one that has clear communication skills, does not judge or shame, and collaborates with patients in a warm and supportive manner. With this approach, there is potential for a strong doctor-patient relationship to be formed, individualized treatment goals solidified, and most importantly, a holistic approach to health established.

**Study Strengths, Limitations, and Areas for Future Research**

The present inquiry employed a qualitative, constructivist grounded theory methodology to uncover the experiences of women receiving weight-related information
or advice from their doctors. Guided by a critical feminist perspective, this study explored sociocultural processes that interacted with women’s understanding and perceptions of weight-based dialogues. The richness of the data obtained through the study facilitated the identification of three fundamental core categories that embodied the doctor-patient relationship, context, and practice. Prior to discussing areas for future research as well as the study’s clinical and educational implications, it is important to acknowledge first that its findings are substantiated in both methodological strengths and limitations, which are discussed in turn.

**Strengths**

One of the primary strengths of the present study was its use of a qualitative methodology, which allowed for a rich delineation of the multifaceted processes underlying weight-based doctor-patient interactions. Given that a considerable amount of research in this domain had been conducted using quantitative methodology in Canada, the current study’s methodology uncovered a more descriptive depiction of Canadian women’s subjective experiences related to weight-based care—an important quality for an area that involves complex social processes. Furthermore, the use of a qualitative design provided the opportunity to explore and better understand participants’ feelings, thoughts, and beliefs associated with doctors’ weight-based dialogues, and through that, derive practical implications for future practice and care.

The use of a constructivist grounded theory approach as the primary means of organizing and analyzing the gathered data placed emphasis on delving beyond surface-level meaning within the data and searching for the deeper underlying meanings related
to participants’ values, beliefs, and ideologies (Charmaz, 2006). The utilization of constructivist grounded theory allowed for rich data collection that was detailed, focused, and wide-ranging. Further, it illuminated the inner dialogues of the participants without sacrificing the importance of the circumstances and backgrounds from which they came. Using a constructivist grounded theory approach also created a valuable opportunity to better appreciate how participants made sense of their experiences with doctors, and to interpret their meanings and actions through a broader lens of lived contexts (Charmaz, 2006).

A critical feminist lens further supported the exploration of women’s lived contexts as well as their interactions within medical environments in relation to their weights. Utilizing such a feminist perspective contributed to the richness of this study by helping to illuminate the complexities of the women’s lived contexts and experiences, while considering such issues as power, gender, ethnicity, and social status. This was important as weight affects experiences not only within the medical environment, but also within other social settings, especially when women do not adhere to culturally sanctioned standards of body weight, femininity, or aesthetic appeal (Goodman, 1995).

The use of both constructivist grounded theory and a critical feminist perspective maximized the space for women’s voices to be heard (Charmaz, 2003). In doing so, the current study provided a more elaborate understanding of women’s lived contexts by focusing on their personal ongoing experiences with body size and weight in relation to cultural norms of appearance, weight stigmas, psychological issues, and physical illnesses. The present study provided an in-depth and detailed depiction of women’s lived contexts, and how in turn context shaped women’s experiences and reactions to their
doctors’ weight-related dialogues. For example, the study reflected how vital patients’ individual contexts were in understanding the complexity of weight-based exchanges with doctors, and the powerful impact of doctors’ dialogues on patients’ self- and body-esteem.

Another strength of the current study was the diversity present among the participants selected. Participants embodied diversity in terms of their ethnocultural backgrounds, socioeconomic status, immigration status, sexual orientation, and former or current weight problems, as well as their body size and weight. This diversity was significant in light of the paucity of weight-management research to date that has included participants from diverse backgrounds. The inclusion of such diversity strengthened the current study by promoting a better understanding of the ways in which the sociocultural contexts of participants’ lives shaped their experiences with doctors’ weight-related dialogues. Studies with diverse groups of participants can help inform and guide Canadian doctors in providing sensitive patient-centred care. For example, it was not just women who were overweight or obese that experienced stigma, but also those deemed in their medical charts as underweight. Lastly, the current study explored both positive and negative interactions and relations with doctors. This area of study tends to be neglected in the field of research on weight-related support in the medical community. However, exploring positive interactions helps in outlining practices that are beneficial in the provision of weight-related care.
**Limitations**

The findings of social research are always bound by certain limitations, and this study was no exception. The size of the group of participants was its first limitation. Theoretical saturation was used to determine the number of participants who were included in the study (Strauss & Corbin, 1998). While the saturation of themes was met, it is possible that further interviews with additional women may have resulted in other themes surfacing.

Despite the ethnocultural diversity of participants in this study, another specific limitation was the lack of representation related to physical (dis)ability, as well as a smaller representation of women in lower weight categories (e.g., underweight to normal weight) when compared to those in higher weight categories (e.g., overweight to obese). Furthermore, the study only included women between the ages of 18 and 45 years as a way of decreasing the potential impact of cohort effects. However, additional themes reflective of the lived experiences of a broader group of women, pertaining specifically to (dis)ability, body weights, and age, would be beneficial for future research. Given the nature of this research, it is important to recognize that self-selection bias may exist in the present study. Specifically, the women who chose to participate may have been exposed to more negative or impactful experiences with doctors than those who did not choose to participate.

An intrinsic limitation within qualitative research is the subjectivity of the researcher. Accordingly, different investigators may have alternate interpretations and identify differing themes and contextual factors that may account for them. The constructivist grounded theory approach acknowledges the collaborative construction of
knowledge by participants and researcher, and the impact of context on the research process (Charmaz, 2000; Mills et al., 2008). In the present study, appreciation of the researcher’s subjectivity supported the importance of staying close to the data in order to maintain an acceptable degree of coherence between text and interpretations.

Collaboration with participants regarding knowledge construction was carried out in the early phases of the data analysis. Participants were provided with a summary of their experiences with doctors and weight, as well as their transcribed interview, in order to confirm an accurate depiction of their experiences. Additional credibility was enhanced by the use of ongoing observation through memo-writing (Charmaz, 2006).

Another limitation of qualitative research pertains to generalizability. Qualitative methodology does not aim for generalizations beyond the group of study participants. Rather, by providing a detailed description of the participant group and their narratives, readers and other researchers can examine whether the results of the study resonate with their experiences or research findings. Lastly, the study did not include a review of the health literacy research. At the time that the study was conceived and conducted, there were no existing studies pertaining to the limitations Canadian GPs face in health-related information delivery.

**Areas for Future Research**

The findings from the present study revealed a number of multifaceted variables that interacted with women’s lived experiences with weight, and how these experiences shaped weight-based dialogues with their doctors. As with any research, the current study highlighted important areas of focus for future studies in weight-related care. In particular, there is a need for future research to further explore women’s experiences with
weight-related care in Canada through a larger and more diverse group of women, considering as well the impact of (dis)ability and a range of body weights and ages. The present study suggested the usefulness of exploring the doctor-patient relationship, the lived contexts of patients, as well as weight-based practice through the use of a feminist-perspective lens to assist in uncovering the complexities of weight-related care. This study was in agreement with Aston et al. (2012) in suggesting the usefulness of a feminist perspective in the explorations of weight-based research with women, as it emphasized the ways in which sociocultural values, institutional structures, and widespread stereotypes shape individuals’ experiences. It would be interesting to further explore specific mediating or moderating properties or protective factors within the doctor-patient relationship that may positively influence women’s reactions to sensitive weight-based care.

It would also be of value to focus future research on exploring how weight-management interventions in medical care can incorporate some of the broader and more complex sociocultural factors influencing individuals’ experience of their weight. Congruent with the present study, weight-control interventions focusing primarily on behavioural strategies have been largely unsuccessful (Lyznicki et al., 2001). Moreover, they hold the implicit assumption that weight loss is possible for everyone through these modes, often resulting in an environment of blame and shame when individuals fail. Results from the present study suggested that considering patients’ varied lived contexts and histories when conducting weight-management interventions is imperative.

As previously postulated, the heavy emphasis on behaviour-based weight-loss prescriptions used by doctors may speak to a larger systemic issue ingrained within the
medical environment (Kirk et al., 2014). Accordingly, the question could be posed as to whether doctors default to eating and exercise advice because these are quick and tangible practices that can be provided within fixed time constraints. Further research may be necessary to shed light on training opportunities that can help doctors consider some of the broader, more complex sociocultural factors that may be harder to distil yet deserve equal attention and time within doctor-patient conversations.

Further research would be useful to refine factors that help improve the delivery of weight-related care. The present study demonstrated that most participants were largely unsatisfied with the ways in which their doctors communicated weight issues, both verbally and non-verbally. This area of research is important as more positive communication and interactional styles from doctors were shown, in the current study, to strengthen the doctor-patient relationship. If in fact there were specific interactional changes that doctors could apply with their patients in order to convey care and compassion, patients may be more inclined to implement these changes into their daily routines.

Lastly, the current study provided substantial support for the necessity of future research to explore how doctors are educated in offering weight-related care for women, as well as to determine how stigma is tackled in medical education curricula. Results of the present study revealed that individuals exhibiting a range of body weights experienced weight stigma when they deviated from normative body standards. The study also suggested that further research is needed in order to explore interventions that aim to reduce stigma and dispel harmful assumptions in weight-related care. The prevalence of weight-based stigma in health care, as well as the negative consequences of stigma on
women’s overall wellbeing, has been vastly documented (e.g., Mold & Forbes, 2013; Goodman, 1995; Puhl & Heuer, 2009; Rogge et al., 2004). It is an opportune time to work within the medical education system to identify, strategize, develop, and implement programs that have the potential to strengthen doctor-patient relationships that promote care and reduce stigma.

**Clinical and Educational Implications**

Findings from the current study have the potential to inform clinical and educational initiatives for doctors aimed at enhancing the quality of services for women involved in weight-related care. Overall, the study suggested that a strong doctor-patient relationship, coupled with the incorporation of a woman’s lived context and history, is an essential feature in the provision of weight-based care. Weight-management interventions that reflect respect, and promote active listening and compassion for the complexity of weight and weight-related issues appeared to positively influence the doctor-patient relationship as well as patients’ self-image. Furthermore, the reconceptualization of weight-related practices must occur in order to incorporate patients’ varied contexts and histories into any weight-based plan. This may also require addressing widely sanctioned weight-related stigmas and biases.

The results of the current study, congruent with the existing literature (e.g., Mold & Forbes, 2013), have suggested that investing time and attention toward building a strong doctor-patient relationship is worthwhile for doctors providing weight-related care. Participants affirmed that an empathic relationship allowed for a comfortable and safe environment in which to discuss vulnerabilities related to weight, as well as worked to
counteract any shame or self-blame they were experiencing. Based on participants’ experiences and formulations of what they would like to see in weight-based care, the women provided a clear depiction of an empathetic and compassionate doctor, one that had strong communication skills, did not judge or shame patients, and who also collaborated with patients in a supportive manner. The women in the present study that had experienced positive weight-based dialogues with their doctors highlighted the importance of a strong doctor-patient relationship that, in turn, positively impacted the quality of care received and the outcomes of weight-management treatment. Doctors training, and subsequent practice, should be informed by the emphasis on relational factors in the provision of patient care.

Findings from the current study also shed light on the ways in which doctors deliver weight-based care. Gleaned from the women interviewed was the shared idea that the topic of weight adds a complex layer to how doctors’ medical messages are perceived. Dialogues about weight proved to be sensitive and impactful. As research has demonstrated, weight is a loaded topic with many sociocultural underpinnings that can evoke shame and blame in women (e.g., Puhl et al., 2008). Two factors proved influential regarding the delivery of care: 1) the language doctors chose to advise women about their weight; and 2) the manner in which doctors said these words, both verbal and non-verbal. Women whose doctors delivered weight-related information and advice in a sensitive and compassionate way described more positive responses to weight-based care. Directives for health care professionals have the potential to capitalize on this knowledge by encouraging doctors to attend to and modify their delivery of weight-related dialogues with women in ways that convey sensitivity, warmth, and compassion.
Also important to weight-based care, the present study demonstrated that the timing and context with which doctors broached the topic of weight was important. Specifically, participants expressed their desire for doctors to treat their existing medical conditions prior to addressing the issue of weight. This was in contrast to doctors blaming any health issue on a patient’s weight, even when medical reports confirmed differently. When existing health issues were focused on prior to any weight-based discussions, participants felt that their doctors were viewing their concerns from a holistic perspective. Supporting doctors in shifting their focus from a person’s weight to their overall health (independent from weight) could be an important first step in both clinical practice and the medical educational system, supported by such initiatives as Health at Every Size (HAES; e.g., Robison et al., 2007). In light of Canadian Clinical Practice Guidelines suggesting that doctors provide weight-management interventions with their patients (Lau et al., 2007), awareness of important factors including strong doctor-patient relationships, as well as sensitive deliveries and timing of weight-based messages, could substantially enhance the quality of weight-based medical care.

Importantly, interactions between doctors and women are burdened by stigmas associated with bodies that deviate from the socially prescribed norms (e.g., Puhl et al., 2008). The results of the present study highlighted the importance of addressing weight-based stigma and stereotypical beliefs that further oppress women seeking care. As was previously stated, both underweight and overweight women reported experiences of weight-based stigma. Doctors therefore need to challenge these stigmas in order to create a comfortable environment for women of all shapes and sizes (e.g., Thomas et al., 2008).
This goal could be achieved through educational initiatives that aim at increasing doctors’ awareness of their personal beliefs about women’s weight and health.

Supporting doctors in challenging commonly held stereotypes about women’s weight and bodies may also be facilitated through the encouragement of practices that incorporate the exploration and understanding of women’s lived contexts and histories. Findings from the current study demonstrated the importance of doctors getting to know their patients’ lived experiences in relation to their weight. Without inquiry into context, participants felt as though the varied barriers and challenges they faced with regards to weight management were not acknowledged. Patients are the experts of their own lives and have important information to share about their lived contexts and histories—information that could substantially improve the suitability and success of any weight-management interventions.

The women in the present study spoke of many variables that had a powerful influence on their weight such as physical illnesses, mental health difficulties, financial limitations, self-worth and self-esteem, cultural stigmas and biases, and conflicting weight messages in society and the media. Results from the current study supported initiatives aimed at highlighting sociocultural pressures faced by individuals. All participants agreed that the traditional prescription of “eat less, exercise more” was unsuccessful due to the fact that it placed the onus on the willpower of the individual, minimizing the complex and multifaceted barriers contributing to weight. The women discussed how, with increased training in the medical education system, doctors could learn to act as educators and informers on how to achieve change while considering the
many sociocultural barriers. This may also necessitate the involvement of health care
teams and varied resources.

Participants in the current study spoke to the potential for doctors to make
meaningful shifts in their weight-based practices that would have a tremendous effect on
the quality of care provided. The women focused on five areas of recommended practice:
interactional skill sets, incorporation of context, collaboration and support, resources and
direction, and the necessity of further training for doctors. It is essential to note, however,
that important clinical implications would be challenging to implement due to the many
barriers doctors face including time constraints, lack of weight-management training, and
an overburdened medical system. Congruent with research conducted by Kirk et al.
(2014), changes in the way doctors practice weight-related care will likely require further
collaboration between patients, health care professionals, educators, and policymakers
alike. To successfully promote change, important systemic modifications must be
addressed in order to better support doctors in providing weight-based interventions that
meet the fundamental needs of women in this domain of care.
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Publications.


APPENDIX A
Participant Recruitment Poster

HAVE YOU EVER RECEIVED WEIGHT INFORMATION OR ADVICE FROM YOUR DOCTOR?

We are looking for women between the ages of 18 – 45 who have received weight information or advice from their doctors and who are willing to talk about these experiences.

Who we are:
My name is Erin King-Brown and I am a PhD student in the Department of Applied Psychology and Human Development at the Ontario Institute for the Studies in Education of the University of Toronto (OISE/UT). I am working on this project for my doctoral dissertation under the supervision of Dr. Niva Piran.

Purpose of the study:
The aim of the study is to explore women’s experiences with weight-related information or advice from their doctors. We are also looking to learn from women’s experiences in order to help inform health care professionals in providing optimal patient-centered support within this area of care.

How can you participate?
Women of diverse backgrounds between the ages of 18-45 who have had their doctors give them weight-related information or advice within the past 2 years, are invited to participate in the study.

Compensation for participation:
Participants will receive a $20 gift card as a token of our appreciation.

If you are interested, or would like further information about this study, please contact us at:
Email: gpweightadvice@gmail.com or Tel: (416)-885-3500

This study has been approved by the University of Toronto Research Ethics Review Board.

(Tear away strips below containing the following information:
‘Women and Doctors’ Weight Advice Study’; Email; Phone Number)
Hello, my name is Erin King-Brown. You left a message for me indicating that you might be interested in taking part in a research project I am conducting that focuses on women’s experiences of weight-related dialogues with their doctors.

Would it be okay to take a few minutes now to speak with you?

**Introduce Researcher and Purpose of the Study:**
I am a graduate student at the (Ontario Institute for the Studies in Education) University of Toronto. I am currently completing my Doctoral degree in Clinical and Counselling Psychology. As part of my degree I am conducting a research project that will explore between 15 and 25 women’s experiences receiving weight-management information or advice from their doctors.

**Limits of Confidentiality:**
In talking with me it is important that you understand the limits of confidentiality:
Any conversation that we have is confidential. However, there are several exceptions to this, including:
If you indicate that you are a danger to yourself or to others, or if you disclose details about apparent, suspected, or potential current child abuse.
If any of these exceptions arise I would be required both legally and ethically to contact the appropriate authority whether that be emergency services, or children’s services. Do you have any questions about this?

*Address any questions.*

**Inclusion and Exclusion Criteria:**
I want to ensure that you noticed the criteria on the poster advertisement that may exclude some women from participating in this study. These criteria include:

1) Age, in that you need to be between the ages of 18-45
2) You have received some type of weight information/advice from your doctor within the last 2 years

If these criteria do apply to you, then I would like to tell you more about the study if you are still interested in participating.

**Nature and Procedure of Study:**
Now I would like to tell you about the nature of the study and what would be involved in your participation to help you decide whether you are interested in being involved.

**Purpose of the Research:** To date, there has been very little research completed in Canada on the experiences of women receiving weight-based information or advice from their doctors. More recently, Canadian Guidelines have recommended that doctors provide weight-control information to their patients, particularly during annual physical exams. We require further research with Canadian women to understand more fully this area of care in order to inform health care providers of how to provide optimal weight-
related communications that are patient-centered and in line with patients’ needs. In order to do that, it is essential that we hear from women themselves and how they describe their unique experiences receiving weight-management directives from their doctors.

If you were to take part in this research it would involve your participation in one 1-2 hour interview, depending on the time you require. Further, an additional 1-hour after our interview would be required for you to review the transcripts and summaries from the interview to ensure their accuracy. This would be done on your own time.

The interview sessions would be audio recorded and these recordings will be transcribed. All information that you would provide during the interviews is kept strictly confidential. However, some excerpts from the interview transcripts may be used in the publication and presentation of the research findings with your name and any other identifying information changed to ensure your confidentiality.

**Location:** Ontario Institute for Studies in Education, University of Toronto - St. George Campus, 252 Bloor Street West, Toronto, ON M5S 1V6, Canada

**Benefits and Potential Harm:** You will be asked in the interview to explore your experiences receiving weight-related information or advice by your doctors. Talking about your experiences may be an enlightening experience for you. However, there is the chance that speaking about your experience may elicit some discomfort as a result of painful or upsetting experiences. I would not be available to provide you with psychotherapy services because this is strictly a research project. However, should the need arise I would assist you with connecting to an appropriate mental health professional or services.

**Compensation:** To thank you for your participation in the study you will be provided with a $20 gift card.

**Address Questions:**
Do you have any questions about the study or any information I have presented?
*Address any questions.*

After hearing about the research project do you think you might be interested in taking part?
*If the individual demonstrates interest in participating:*

I would like to send you the informed consent letter so you can more carefully read through the guidelines for the study, and decide whether you would like to commit to taking part. I will then contact you in about a week's time and you can let me know if you would like to participate. Is this okay with you?

*If the individual is not interested in participating:*
Thank you for taking the time to speak with me.
APPENDIX C

Informed Consent Form

Weight-Related Messages In Primary Care: Challenges And Possibilities

Dear Participant:

My name is Erin King-Brown. I am a doctoral student, working with Dr. Niva Piran, in the Department of Applied Psychology and Human Development at the Ontario Institute for Studies in Education of the University of Toronto (OISE/UT). I am asking your permission to participate in the research project I am doing relating to the experiences women have had receiving weight advice from their doctors.

Please read the following information carefully and inform me if you have any questions or concerns before signing your consent.

Purpose of the Research
To date, there has been no qualitative research completed in Canada on the experiences of women receiving weight-management information from their doctors. More recently, Canadian Guidelines have recommended that doctors provide weight-control information to their patients, particularly during annual physical exams. We require further research with Canadian women to understand more fully this area of care. In turn, we can help inform and support health care professionals in providing optimal weight-related communications that are patient-centered and in line with what patients need. In order to do that, it is essential that we hear from women themselves and how they describe their unique experiences receiving weight-management directives or advice from their doctors.

Description of the Research
I am looking to interview 15 to 25 women of diverse backgrounds and experiences who have had their doctors provide them with weight-related advice within the past 2 years.

If you agree to participate, I will interview you once for about 1 to 1.5 hours, depending on how much time you need. In the interview, I will ask you about your experiences receiving weight-management advice from your doctor. I will ask you about any further thoughts and views on this topic and will ensure I fully understood your experiences. I will be using a digital mp3 recorder to audio tape all the interviews. Within a month of meeting, you will be mailed a summary of our interview, as well as a typed copy of the interview itself. I will ask that you review the summary and interview and return them with any feedback or clarifications. The interviews will take place at a private room at the Ontario Institute for Studies in Education at the University of Toronto or another place of your choosing. When I have completed the study, I will be glad to share with you the results.

Confidentiality
Confidentiality will be respected and your identity will be protected unless required by law. The mp3 recordings will be immediately transferred to a password protected and encrypted computer file for 1 year and then destroyed. The mp3 files on the recorder will also be deleted at this time. The audio files will be transcribed and all identifying names and information will be removed from the transcripts. The
transcribed material will be identified by a research code only and all identifying information will be erased. This material will be kept in locked files until five years following the completion of the study, at which time they will be shredded. For any publication related to this research, we will ensure that all identifying information will be omitted so that you will not be identified. The one exception to this is the very unlikely event that you indicate that you might do serious harm to yourself or others, or that someone under the age of 16 is being harmed in any way. If that were to happen, I am obligated by law to make a report to the relevant officials.

**Potential Benefits**

In terms of direct benefits, individuals often express an interest in having the opportunity to talk about their experiences. Furthermore, a greater understanding of women’s experiences with weight-related directives will help inform the development of culturally relevant protocols for weight-management treatments in line with strategies to enhance the doctor-patient relationship that promotes care, reduces stigma, and meets the fundamental needs of patients within this domain of care.

**Potential Harms, Discomforts or Inconveniences**

There are no known harms associated with participation in this study. The only potential risk I have identified is that you may feel some discomfort when talking about your experiences. In this case, you may decline to participate. If you decide to participate you may skip any question, request a break, or withdraw from the study at any time. If you choose to withdraw, audio recordings of your interviews will be deleted, and transcripts of your interview will be destroyed. You will be free to keep any compensation that had already been provided to you.

Throughout the interview I will check-in with you regarding how you are feeling. Please let me know at any time should you feel any discomfort. Following the interview, if you continue to experience discomfort, please contact me so that we can discuss ways in which I can support you in connecting with a mental health professional. Should you decide to withdraw your permission to participate in the study, please let me know about your decision by telephoning me at the number below.

**Compensation**

To thank you for your participation in this study, $20.00 will be provided to you.

If you have any questions about the study, please contact me, Erin King-Brown, at the telephone number or email address listed below.

If you would like to receive a copy of the research findings after the study has been completed, please fill out the attached form that will be kept in a separate locked file in my office.

If you have any further questions or comments, please contact either myself, Dr. Niva Piran, or the Ethics Review Office.

Sincerely,

Erin King-Brown, M.Ed., Ph.D. Candidate OISE/UT
Email: erin.king.brown@mail.utoronto.ca
Tel: (416) 885-3500
Consent to Participate
I have read and understand this consent form and what is required of my participation in this research study. I understand that I have the right to withdraw from this study at any time without consequence, and that I may choose to skip any questions I feel uncomfortable answering.

I consent to my participation in this research study, and to being audio taped during the interview.

Name (printed): __________________________________________
Address: __________________________________________
________________________________________
________________________________________
Phone Number: __________________________________________
Email Address: __________________________________________

Signature: __________________________________________
Date: __________________________________________
APPENDIX D

Request for Summary of Research Findings

I wish to receive a summary of the findings for the research entitled:

“Weight-Related Messages In Primary Care:
Challenges And Possibilities”

Yes_______  No_______

Name: ________________________________________________

Address: ________________________________________________

Phone Number: __________________________________________

Email Address: __________________________________________
APPENDIX E

Suggested Counselling Resources

**University of Toronto Counselling Centre**
214 College St.
Toronto, Ontario
Tel: 416-978-7970
Service is free of charge for University of Toronto students

**Women’s Brief Psychotherapy Centre**
2 Carlton St. (18th Floor)
Toronto, Ontario
Tel: 416-519-2000
Service is free of charge. A waiting list may apply

**OISE Psychoeducational Clinic**
OISE/UT
252 Bloor St.
Toronto, Ontario
Tel: 416-923-6641 ext. 2569 (Director: Judy Silver)
Service involves a minimal (or no) charge.

**College Street Women’s Centre for Health Education and Counselling**
489 College St.
Toronto, Ontario
416-929-1816

**Gerstein Centre**
100 Charles St. East
Toronto, Ontario
The Gerstein Centre provides a crisis line: 416-929-5200 (24 hours)
It also provides a 24-referral service: 416-929-9897

Your General Practitioner may also be a good source for local practitioners working within the mental health field.

Please do not hesitate to contact Erin King-Brown (416-885-3500) for assistance in finding additional counselling resources.
APPENDIX F

Interview Questioning Guide

*How did you hear about the study?
*What would you like the research code name to be?
* For the transcription and summary, how would you like it sent?

[Introduce the study]
We are interested in exploring women’s experiences receiving weight-related information advice from their doctors. To date, there has been little research completed in Canada on the experiences of women receiving this type of advice or information from their doctors. More recently, Canadian Guidelines have recommended doctors provide weight-related information to their patients, particularly during annual physical exams. The aim of the study is to understand women’s experiences in order to better inform and support health care professionals in providing optimal patient-centered care in this area.

Participants’ Interest in Taking Part in the Study:
- We appreciate your interest in participating in this study. What made you interested in this study?

Demographic Information:
We will start by getting some basic demographic information. If you are not comfortable answering any of the questions you are more than welcome to pass.
- What is your age? Date of birth?
- What is your country of origin? Year immigrated to Canada? First language?
- What is your ethnocultural background?
- What is your marital status or relationship status?
- Do you have any children?
- What are your current living arrangements?
- What do you consider your socioeconomic status to be (e.g., low, middle, upper class)?
- What is your sexual orientation?
- What is your highest level of education?
- What is your employment status/occupation? (e.g., fulltime, part-time, unemployed)
- To the best of your knowledge, what is your height and weight?
- To the best of your knowledge, what is your height and weight at the time of the dialogue?
- Do you have any disabilities/challenges?
- Are you currently on any medication?
- How would you describe your current health status?
- How would you describe your past health status?
- Have you had any struggles with your weight/body in the past?
- Do you have any struggles with your weight/body currently?
- How do you feel, in general, about your health and body at the present moment?

DOCTOR Demographic Information:
- Where if your doctor’s office location (e.g., urban or rural)?
- What type of visit were you attending (e.g., yearly physical or specific concern)?
- What was your doctor’s gender?
• What was the approximate age of your doctor?
• What was the ethnocultural background of your doctor if you can recall?
• How long have you known your doctor for or how many visits have you seen your doctor for?
• Anything else that would be helpful to know about your doctor?

**Primary Question:**

*You are an expert in that because you have experienced the delivery of such advice.*

*It may be helpful to start by thinking back to the time of the dialogue, sitting in the office, hearing the words from your doctor as he/she talked about your weight …*

**Tell me about a time when you received weight-related information or advice from your doctor…**

*Advice Focused*

- How did the conversation regarding your weight come about?
- Do you remember what was said to you?
- What was your doctor’s weight-related information and/or advice?
- How did he/she convey this information to you (e.g., verbal, pamphlet, etc.)?

*Experience And Self Focused*

- Can you tell me about some of your thoughts, feelings, and reactions during the course of the dialogue?
- Can you tell me about some of your thoughts, feelings, and reactions after the dialogue?
- How did you feel about your body before your doctor discussed your weight?
- How did you feel about your body after your doctor discussed your weight?
- How did you feel about the way he/she delivered or talk about the weight advice?
- Can you think of anything your doctor may have said or did while providing you with weight-management information that you found unhelpful or negative?
  - Was there anything you wish he/she had done differently, or approached in a different manner?
- Can you think of anything your doctor may have said or did while providing you with weight-management information that you found helpful or positive?
  - Was there anything that you would like your doctor to continue doing or implement that would be helpful in this area of care?
- What was going on in your life during the time of the advice?
- How, if at all, did this conversation impact you?
  - How did it impact your eating/exercise habits?
  - How did it impact your approach to food?
  - How did it impact the experience you had with others (e.g. eating, enjoying eating, etc.)?
  - How did it impact future medical appointments or seeking healthcare support?
  - How did it impact any other areas of your life?
- What are some of your individual needs when receiving weight-related advice?
- What type of care would be best for you in terms of weight management?
- What do you expect from your doctor? What do you think the role of the doctor should be regarding weight?
• After speaking about and reflecting back on your experience receiving weight advice, is there anything else that is coming up surrounding how you currently feel about your body? About the experience?

[More of a general sense of health]

• What are your personal views surrounding ‘health’ and being ‘healthy’?
  ▪ What is ‘health’ to you?
  ▪ Has this changed over the years? If so, what were the influencing factors?
• What were your family’s views surrounding health that you were raised with?
  ▪ How did these views influence you?
• What do you think your doctor’s views are surrounding health and weight?
• What do you think your doctor’s knowledge is surrounding health and weight?
  ▪ Do you think your doctor has any prejudice about health and weight?
    • How did you see this?
    • How does it affect you as a patient?
    • Do you think your doctor considers barriers to attaining health?
    • How does this effect usefulness of the information provided?
• What do you think the current societal views are surrounding ‘health’ and being ‘healthy’?
• What has had the most influence on you regarding your health/weight?

• What are some of the things you would like doctors to consider/do when having weight-related dialogues with women in the future?

Closing:

• Thank you for your valuable information. Is there anything else that we have not talked about today that you would like to share?

• What was it like for you to participate in this interview?

• Any questions you would like to ask me?
APPENDIX G

Final Coding Scheme

1. Core Category: WEIGHT WEIGHING ON THE DOCTOR-PATIENT RELATIONSHIP

Categories:
1. Weight and Power in the Doctor-Patient Relationship
   
   Themes:
   i) Unsolicited Advice
   ii) Delivery of Weight-Related Dialogues
   iii) Expression of Negative Stereotypes Regarding Weight and Bodies
   iv) Loss of Voice
   v) Importance or Trust Placed on Doctors

2. Weight in Context
   
   Themes:
   i) (No) Exploration or Importance Placed on Social Location
   ii) (No) Exploration or Importance Placed on Biological, Medical, or Psychological Histories
   iii) (No) Exploration or Importance Placed on Participants’ Individual Lifestyles
   iv) (No) Exploration or Importance Placed on Other Variables Contributing to Presenting Medical Concerns

3. Weight and Health in the Medical Room
   
   Themes:
   i) Assumptions About Health and Weight
   ii) Role of Doctors in Weight Management
   iii) Patients’ Understanding of Doctors’ Constraints

4. Meaningless Scripts
   
   Themes:
   i) Restricted Dialogue
   ii) Overuse of Weight Messages
   iii) (No) Exploration of the Correlation Between Weight and Health
   iv) Perceived Lack of Knowledge Related to Weight-Management Interventions

2. Core Category: PATIENTS’ SELF AND BODY EXPERIENCES

Categories:
1. Ongoing Medical, Psychological, and Social Encounters
   
   Themes:
   i) Medical Issues
   ii) Mental Health Struggles
   iii) Weight Stigma and Discrimination
   iv) Societal Influences, Ideals, and Norms
   v) Cultural and Familial Influences
2. Weight-Related Experiences in the Everyday
   **Themes:**
   i) Weight-Related Activities, Struggles, Barriers, and Consequences
   ii) Self-Objectification
   iii) Body Surveillance

3. Patients’ Self and Body Experiences in Relation to the Doctor-Patient Interaction
   **Themes:**
   i) Emotional Reactions
   ii) Behavioural Reactions
   iii) Contesting Responses
   iv) Invalidating and Dehumanizing Experiences
   v) Reactions to the “Fat” Label
   vi) Body Esteem

3. Core Category: PRACTICE

**Categories:**
1. Practice As Is
   **Themes:**
   i) Physical Activity
   ii) Diet
   iii) Combination of Physical Activity and Diet
   iv) Suggested Weights
   v) Time and Attentiveness

2. Recommended Modes of Practice
   **Themes:**
   i) Quality of Human Dialogues
      **Subthemes:**
      a) Human-to-Human Interactions
      b) Thoughtful Delivery and Tone
      c) Non-Judgmental and Empathetic Communications
      d) Personable
      e) Sensitive
      f) Two-Way Conversations
   ii) Consideration of Personal and Social Context
      **Subthemes:**
      a) Understanding Lifestyles
      b) Attentive to Mental Health
      c) Mindful of Disordered Eating Backgrounds and Weight Preoccupations
      d) Appreciation of Systemic Factors
   iii) Professionals as Facilitators of Change
      **Subthemes:**
      a) Normalizing
      b) Encouraging
      c) Exploring Why Patients are Struggling with Weight
      d) Explaining the Medical Issues Associated with Particular Weights
iv) Informed Plans

**Subthemes:**

a) Creativity and Open-Mindedness
b) Individualized Plans
c) Verbal Information and Advice
d) Written Information and Advice
e) Guidance and Direction
f) Follow-Ups and Referrals

v) Doctors’ Training