The Stories of Fat Women Accessing Healthcare in Saskatchewan

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Sydney Louise Bell

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SUPERVISORY AND EXAMINING COMMITTEE

Sydney Louise Bell, candidate for the degree of Master of Social Work in Social Work, has presented a thesis titled, *The Stories of Fat Women Accessing Healthcare in Saskatchewan*, in an oral examination held on December 2, 2016. The following committee members have found the thesis acceptable in form and content, and that the candidate demonstrated satisfactory knowledge of the subject material.

External Examiner: Dr. Marie Lovrod, Women’s and Gender Studies, University of Saskatchewan

Supervisor: Dr. Darlene Chalmers, Faculty of Social Work

Committee Member: *Dr. Bonnie Jeffery, Faculty of Social Work

Committee Member: Dr. Ailsa Watkinson, Faculty of Social Work

Chair of Defense: Dr. Elise Matthews, Faculty of Nursing

*Via teleconference*
Abstract

The research question posed within this study asks: What are the experiences of women who identify as ‘fat’ or ‘overweight’ in accessing healthcare in Saskatchewan? The ideology of ‘fat is bad, thin is good’ is buried deep within our cultural psyche. Utilizing a narrative methodology, an in-depth understanding of the lived experience of fat women pursuing health through engagement with the health care system was sought. Specifically, potential barriers such as attitudes of health care providers, shame due to weight stigma, and lack of proper equipment impact the ability of fat women to access health care services were explored. New insights into how women who live in larger bodies are exploring their own understanding of health, challenging the default obesity diagnoses of their healthcare providers, or exercising their power by changing healthcare providers were revealed. This thesis concludes with implications for potential positive change in the delivery of health care and social services that is supportive and welcoming to people of all sizes.
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Chapter 1 – Introduction

Introduction

How do gender norms and weight stigma intersect and shape fat women’s lives and experiences of health? People who live in fat bodies face increasingly alarmist messaging about the state of their health and well-being (Bacon, 2010; Campos, Saguy, Ernsberger, Oliver, & Gaesser, 2006). In a culture that places a high value on thinness, messages warning us about increasing waistlines linking fatness with ill health are omnipresent. In recent years, the tone of these messages has shifted from general concern about possible bad health outcomes for fat people to alarmist messaging that is underpinned by fear, moral panic, and weight stigma (Bacon, 2010; Burgard, 2009; Campos, 2004). However, little is known about the interaction of weight stigma and women’s health as experienced by women who consider themselves fat. What are their experiences pursuing health through interactions with the health care system?

The lived experience of fat women interacting with the health care system would be a helpful contribution to understanding how our cultural view of weight and health, especially the norms and practices in our health care system, impact the health and well-being of larger-sized women whose fatness is often blamed for negative health outcomes (Bacon, 2010; Campos, 2004). Hearing and endeavouring to understand the stories of fatter women will provide opportunities to explore access to health care as well as improving best practices in health care, with the end hope of increased health and well-being for these women.

The language of fat. The target group for this research is women who self-identify as ‘fat’ or ‘overweight’ or ‘plus-size’. I included the terms ‘overweight’ and
‘plus-size’ in my recruitment materials because many people have a negative association with the word ‘fat’ and to use it exclusively may have limited my pool of potential participants. However, throughout this document I have chosen to generally use ‘fat’, ‘fatter’ or ‘larger-bodied’ as descriptors of people with larger than average bodies. This choice is about being part of a larger effort to reclaim the word from societally imposed negative connotations and to resist the dominant rhetoric about fat people. There is power in shifting our relationship with words that are used to oppress people by reclaiming them and using them. As this research has a focus on healthcare, it is important to also note my choice not to use terms like ‘overweight’ and ‘obese’ unless as a quotation from a participant or cited reference material. Terms such as ‘obese’ and ‘overweight’ contribute to the medicalization/pathologizing of fat bodies and the current practice of body size as a diagnosis. The word fat is simply a physical descriptor, as is thin, tall, short, and reclaiming it as such is an important step in reducing weight stigma in healthcare.

**Framework and General Research Question**

The research question posed within this study asks: *What are the experiences of women who identify as ‘fat’ or ‘overweight’ in accessing healthcare in Saskatchewan?*

The ideology of ‘fat is bad, thin is good’ is buried deep within our cultural psyche. This dichotomy plays a role in shaping our societal values influencing both how we pursue health on an individual level, and deliver health services on a societal level (Daghofer, 2013). Although the entrenched negative associations with larger body size impact all fatter people, the aim of this research is to focus on the experiences of women. The notion of weight discrimination as an issue that particularly impacts women is not
new. It is well documented that women are more harshly punished for fatness, both in the workforce and in relationships (Correll, 2010; Fikkan & Rothblum, 2012). Fat discrimination has been suggested as a proxy for gender discrimination because the intersection between weight stigma and the oppression of women is so intertwined (Correll, 2010). Theorists further suggest that any discussion of weight stigma must also look at the intersections of gender, race and economic oppression (Correll, 2010; Friedman, 2012). The link between obesity and poverty is well documented (Correll, 2010), and the gendered wage gap within the population of people considered ‘obese’ may represent the most tangible explanation of elevated levels of fatness among low income women. Although there is much evidence to support the notion that being poor makes people fatter (i.e. lack of nutritious food and recreation opportunities in low income neighbourhoods), awareness of the reality that being fat makes people (especially women) poor is necessary (Ernsberger, 2009).

Women are socialized more than men to care about the perceived attractiveness of their body and to take a more active role in pursuing health. Although both men and women face pressure to conform to socially prescribed ideals of attractiveness, women’s place in society and self-worth is more vulnerable to attack due to perceived unattractiveness (Wolf, 1991). Additionally, women are conditioned to be concerned about health and well-being and face greater recrimination for living in a fat body. Fat women are often perceived as not caring enough for their health and appearance. Not only are women held more responsible for their own health, but also face a societally imposed responsibility for the health outcomes of their families, (Chrisler, 2012; De Brún et al., 2013). This is reflected in the contrasted content of women’s and men’s magazines
and “Dr. Mom” themed commercials on television, exemplifying the gendered weight and health discourse that exists throughout the media (De Brún et al, 2013).

The meanings attributed to body size through the experience of gender impacts personal health experiences. As such, the exploration of how fat, health, and gender intersect in this study will be approached through a feminist theoretical framework. The experiences of the research participants will be considered through a gender lens, exploring the power dynamics at play in how fat women experience pursuing health.

**Purpose.** The purpose of this study was to gain an in-depth understanding of the lived experience of fat women pursuing health through engagement with the health care system. Specifically, this study sought to examine how potential barriers such as attitudes of health care providers, shame due to weight stigma, and lack of proper equipment impact the ability of fat women to access health care services. Further, what impact did these potential barriers have on the day-to-day pursuit of health and well-being?

To achieve this purpose, the study explored the stories of women who identify as ‘fat’ or ‘overweight’ pursuing healthcare in Saskatchewan. The aim was to provide a venue for these stories and to access women’s wisdom in understanding the complex interplay between attitudes about weight and the health care received. Through exploring their stories in-depth I hope gained a rich understanding of the health care experience of women living in larger bodies. This kind of understanding contributes to awareness of the experiences of fat women accessing healthcare in Saskatchewan and provides the groundwork for a shift in the delivery of health care that is supportive and welcoming to people of all sizes.
**Background to the study.** My own experiences with body shame and how it impacted my health habits and attitudes has sparked my interest in the topic of weight and health and has informed my point of view. Within a feminist theoretical framework it is important to acknowledge the relationship of the researcher to the topic of study and to consider how my own experiences and understanding of the phenomena may influence or shape the data generated.

My life has been impacted by body shame, shaped by living in a larger-sized body. Internalized weight stigma decreased my self-esteem and impacted my ability to fully engage in the community and kept me from pursuing life dreams earlier in my life - such as a career in the theatre arts. With increasing age and education came a growing acceptance of my body shape and size, and a pursuit of better health practices.

My active pursuit of better health coincided with anxiety issues I experienced about ten years ago that culminated in a diagnosis of a thyroid condition in my late thirties. These diagnoses and the direct impact of anxiety on daily life were motivating factors in a shift to implement more consistent self care into my daily life that included regular exercise and improved nutrition. This experience led me to question my motives for self-care. Realizing that weight loss, or the promise of possible thinness, had not been a successful motivator for sustained lifestyle change as demonstrated in my twenties and early thirties, I became curious as to what motivates larger-sized people to care for their health. For me, it was increased self-acceptance and the need to address a daily health challenge and the troublesome anxiety that I experienced in my late thirties. These challenges successfully motivated me to engage consistently in self-care and healthy lifestyle choices that included improved nutrition and exercise. My personal experience
suggested to me the ineffectiveness of the pursuit of thinness as a sustaining motivator for engagement in healthy lifestyle practices. At this realization I became curious about other people’s experiences. The research and community connections I made seemed to affirm my experience was a common one. Why, then, I wondered, does so much of our efforts to improve health and encourage healthy behaviours focus on weight?

I continue to share the lived experience of a woman living in a fat body that is often assumed to be unhealthy. Over the past few years my own journey has lead me to consider the experiences of all larger-sized people looking to increase their health through lifestyle change. A larger cultural fixation on thinness and weight loss seems to be counter-productive to producing long-term lifestyle change and, as such, I have joined the larger community of body positive activists who speak out against weight stigma and encourage body acceptance for people of all sizes.

**Study Significance**

Upon reviewing weight and health literature, it appears there is little opportunity for women to share their stories of accessing health care when living in a fat body. This lack may be a result of the deep internalizing of our societal fat bias, which has rendered the oppression faced by people living in larger bodies almost invisible (MacInnes, 1993). Providing a space for these stories is important because the consequences for women who face barriers to healthcare due to their weight can be dire, as highlighted in this woman’s story of her mother’s relationship with her doctor:

* A few days before she died, she fell down in a parking lot. Tripped, I guess. The coroner said that may have been what dislodged the blood clot which eventually killed her. Of course, if she’d been getting decent medical care, she might have gotten proper
treatment for all this long before, and maybe she’d still be alive today. But, you know, that doctor had told her not to come back until she’d lost 50 pounds, and she trusted him. She took him to heart. He was a doctor, after all. I hope he’s proud of himself. His words, over 20 years ago, helped kill my mother. She spent her last two days in pain, having difficulty breathing, and not once did she call a doctor or try to get some help.

You see, she still hadn’t lost that 50 pounds (Thorn, 2007).

Stories like this one demonstrate the importance of exploring the impacts of reduced access to health care that fatter people face. Puhl and Heuer (2009) explore the issue of weight stigma and health care in depth and suggest that whether due to shame because of weight stigma, lack of proper equipment or not accessing a primary care physician on a regular basis, fat people are at risk of increased morbidity. Weight stigma in health care is evident in both the use of obesity as a default diagnoses and in how health care practitioners feel about and interact with fatter patients. Puhl and Heuer (2009) highlight a UK study that indicates 84% of patients agreed that weight is to blame for most medical problems (p. 946). This is problematic because it increases patient body shame and leaves fatter people at risk of undiagnosed illness when health care providers do not look beyond body size. Health care professionals are not immune to weight bias, and often hold common weight-based stereotypes such as fatter people being lazy, lacking in self-control and non-compliant (p. 944). As the story above illustrates, these negative views of fat people can cause shame that keeps fat people from accessing health care services, increasing risk of serious illness and death.

When looking at the experiences of larger-sized women accessing healthcare, it is important to be cognizant that current health programs and services in Canada are
generally grounded in what is commonly referred to as a traditional approach to weight and health (Daghofer, 2013). This traditional approach is one that tends to equate larger-sized bodies with negative health outcomes, accompanied by a general concern that the population is getting fatter at an alarming rate. Interventions for fatness are sought, often by prescribing intentional weight loss to avoid the feared deleterious effects of higher body weights (Bacon, 2010; Daghofer, 2013; Pederson et al., 2013). Weight as a proxy for health has been further entrenched within the medical community by the recent classification of obesity as a disease by the World Health Organization and Health Canada (Pederson et al, 2013).

This traditional approach underpins current understanding about weight and health and has an increasing pool of critics who suggest elements of this approach are potentially problematic. For example, within this traditional framework fat people are assumed to have to change their bodies and become thinner to positively impact their health (Daghofer, 2013). It is argued that this assumption contributes to the stigma of having a fat body, which is not only considered unattractive by the majority of the population, but additionally is broadly assumed to be intrinsically unhealthy. Weight stigma is considered problematic because of the adverse impact it has on health (Puhl & Heuer, 2009; Muennig, 2008). The treatments prescribed for fatness such as restrictive diets and weight loss surgery have the demonstrable potential to negatively impact health (Bacon, 2010). Finally, weight cycling (or yo-yo dieting) is another potentially harmful outcome of an approach to weight and health that focuses on weight loss as a goal (Tylka et al., 2014).

For social workers, ethical considerations of working within the traditional
paradigm of weight and health emerge when examining the impacts of weight stigma such as reduced access to health care and education for fat people. Weight stigma is pervasive in our culture and the impacts are so conspicuous that increasing numbers of social workers are considering how weight stigma may be conceived as a social justice issue (Friedman, 2012). In addition to the potential harmful impacts of the traditional weight loss interventions prescribed to combat fatness, social workers are compelled to consider not only the prevalence and impacts of weight stigma, but to consider how fatness intersects with other issues such as poverty, gender and race inequality (Friedman, 2012; Cooper, 2010).

On a broader level, social workers may also consider how the fear of fat propagated in the traditional medical model of weight and health is potentially a tool for social control. For example, the language of the ‘obesity epidemic’ could be considered a tool of the continued oppression of an entire (and easily identifiable) group of people whose vulnerability is exploited for profit by the beauty and fitness industries (Bordo, 2003; Maclnnis, 1993). Burgard (2009) suggests that ‘deeming any particular BMI as pathological is a political, rather than scientific act.”

**Summary**

This chapter began with a discussion about the concept of weight stigma and reviewed the current understanding of fat bodies when it comes to health including a brief discussion on the language of fat, acknowledging the choices I have made regarding the words used to describe people who live in larger bodies. I argue that this study provides an opportunity to fill in the gap created by the silencing of fat women and underlines the importance of finding and including these voices to improve access to healthcare and
health outcomes. The feminist theoretical framework was explored and I offered my reasoning for focusing on the experiences of women in this study.

The next chapter presents the literature reviewed in preparation for this study. I explore the impacts of weight stigma, compare different weight and health paradigms, and look at how feminist scholars have addressed the issue of weight and access to health care.
Chapter 2 – Literature Review

Introduction

I conducted a literature review with three themes and my research question in mind. First, I explored the different approaches to weight and health in Canada, ranging from what’s known as the traditional approach to an emergent weight neutral approach known as “Health at Every Size® (HAES)”. Understanding the ways in which weight is considered to impact health helps to understand what might be influencing interactions between health care professionals and fat patients. Second, weight stigma and its impacts on the lives of fat people was researched, including specific instances of weight stigma existing within the healthcare field. Understanding stigma, particularly weight stigma provided context for the stories of fat women accessing health care. Finally, literature on feminism and fatness was reviewed in order to understand the gendered perspective on the issue of weight and access to health care. These perspectives demonstrate the need to focus this study on the stories of fat women pursuing health.

Approaches to Weight and Health

The literature reviewed described two distinct approaches or frameworks for looking at the relationship to weight and health within a healthcare setting. The first is a traditional approach based on an assumption that higher weights negative impact health. The second is a newer, emergent framework that encourages a critical examination of the traditional assumptions about weight and health.

The traditional approach. It is important to consider the framework through which larger bodies are viewed when studying the stories of women who live in fat bodies and their experiences accessing healthcare. Having a critical understanding of the
generally accepted relationship between weight and health increases awareness of what drives the interactions between health care professionals and fat patients. Recent literature describes a ‘traditional’ approach to weight and health in comparison to an emergent ‘weight neutral’ approach (Pederson et al., 2013; Tylka et al., 2024). The traditional approach to weight and health is predicated on the notion that fat, or adipose tissue, is intrinsically unhealthy. Fatness, viewed through that lens, becomes the default indicator of health on both an individual and public health level (Campos, 2006). This broad-based concern is currently framed with the language of ‘obesity epidemic’.

Interventions both on an individual or public health level focus on weight reduction with restrictive diet plans and increased physical activity (Bacon & Aphramor, 2011).

The recent classification of obesity as a disease by the World Health Organization and Health Canada, further embeds the notion of a larger body size being a predictor of ill health (Pederson et al., 2013). In Canada, a report called “Rethinking Women and Healthy Living in Canada” was produced in partnership with the British Columbia Centre of Excellence for Women’s Health, the Prairie Women’s Health Centre of Excellence and the Atlantic Centre of Excellence for Women’s Health. The report warns that “body weight classification have, increasingly come to define women and men, boys and girls, as healthy or unhealthy” (Pederson et al., 2013, p.73).

In 2013 the Provincial Health Services Authority in British Columbia published the report “From Weight to Well-Being”. The report was described as “a review of research into the interrelationships among obesity, overweight, weight bias and mental well-being” (p. 5). The report explores four weight and health paradigms (Daghofer, 2013). Paradigm One and Two are a comprehensive look at what is known as the ‘traditional’
approach to weight and health, with Paradigm One concerned about the impacts of weight at an individual level and Paradigm Two considering the broader societal context. The last two paradigms reflect an emergent approach to weight and health that is weight neutral. Paradigm Three emphasizes individuals attaining the best weight possible by optimizing psychological and physical health and focusing less on how much a person weighs. Paradigm Four highlights the need to move beyond the individual level to act on the broader socio-environmental context to promote positive mental health and physical well-being for people of all sizes (Daghofer, 2013).

The first two paradigms promote achieving and/or maintaining a pre-determined ‘normal’ body weight as a path to health and encompass the traditional approach to weight and health. Within these first two paradigms the Body Mass Index (BMI) is most often used to determine what is considered ‘normal’, and therefore healthy. In Paradigm One, individuals are encouraged to reduce caloric intake and increase physical activity to reduce weight in order to be healthy. Paradigm Two takes a broader, ecological approach to weight and health, arguing that the blame for the so-called ‘obesity epidemic’ cannot be laid solely at the feet of individuals and their lifestyle choices (Daghofer, 2013). Critically analyzing what is referred to as our ‘obesogenic’ environment, the solution to the ‘obesity epidemic’ in Paradigm Two is considered to be addressing issues such as poverty, food security and access to sport and recreation (Daghofer, 2013). Paradigm Three and Four will be considered more closely in the next section.

Critics of the traditional paradigm such as Bacon (2010); Campos et al. (2006) and Tylka et al. (2014) suggest it is underpinned by deeply ingrained but scientifically unsupported assumptions about weight and health. First is the assumption that fat people...
are at higher risk of death and illness. Second is the assumption that losing weight is the only way for fat people to improve their health and prolong their life, which leads to further assumptions that pursuing weight loss is a good idea and that weight loss is achievable by everyone with the right plan and will power. Finally, within the traditional approach it is broadly held that fat people are an economic burden because of increased health care costs associated with obesity (Bacon & Aphramor, 2011).

A critical examination of these assumptions and the science behind the traditional paradigm is needed to understand why the traditional approach to weight and health is increasingly being viewed as problematic in some academic and healthcare circles. Critics of the traditional paradigm such as Linda Bacon, Paul Campos and Deb Burgard suggest the causal link between larger body size and negative health outcomes does not hold up under closer examination of research data. Many of the studies linking fatness and bad health frequently lack consideration of other variables contributing to health outcomes such as metabolic fitness, exercise, diet quality, weight cycling, diet drug use, economic status, or family history (Bacon, 2010; Burgard 2009; Campos et al., 2006). When these other variables are controlled for in studies, the rationale for suggesting a causal relationship between fatter bodies and negative health outcomes is greatly reduced, and in many cases disappears completely (Bacon, 2010; Campos et al., 2006). It is interesting to note that activity level emerges as a variable that is a more reliable predictor of health status than body size (Bacon, 2008). As a health indicator, activity level operates independent of body size, in that one can be fat and fit, or thin and unfit. Studies suggesting that fat people who are active have better health outcomes than thinner people who are inactive (Bacon, 2008) are compelling to consider, and suggest
that using weight as a de-facto indicator of health is seriously misguided.

Bacon and Aphramor (2011) reviewed six clinical trials. They suggested “a HAES [Health At Every Size®] approach is associated with statistically and clinically relevant improvements in physiological measures (e.g. blood pressure, blood lipids), health behaviours (e.g. physical activity, eating disorder pathology) and psychosocial outcomes (e.g. mood, self-esteem, body image)” (p. 2). Bacon & Aphramor (2011) also reviewed data that addressed some common myths associated with weight and health. One such myth is the idea that anyone who is determined can lose weight and keep it off through appropriate diet and exercise. Evidence to dispel this commonly held belief was reviewed, highlighting long-term follow-up studies that “document that the majority of individuals regain virtually all of the weight that was lost during treatment, regardless of whether they maintain their diet or exercise program” (Bacon & Aphramor, 2011, p. 5).

To illustrate further the ineffectiveness of dieting, Bacon and Aphramor (2011) shared results from The Women’s Health Initiative, a study recognized as the “largest and longest randomized, controlled dietary intervention clinical trial, designed to test the current recommendations” (Bacon & Aphramor, 2011). More than 20,000 women maintained a low-fat diet, reportedly reducing their calorie intake by an average of 360 calories per day and significantly increasing their activity for eight years. Statistically significant weight loss is not experienced by the study participants (Bacon & Aphramor, 2011).

The traditional paradigm has also been criticized as an ineffective approach to weight and health, particularly in its stated goal of addressing ‘obesity’ in North America. This has been evidenced by a lack of decrease in the fatness of the population since the
upsurge in promoting weight loss for health started in the late 1980’s. As a result, critics are claiming there is no reliable process for effective long-term weight loss for most people (Gaesser, 2009). Bacon & Aphramor (2011) suggest further consideration of how the traditional paradigm “is ...also damaging, contributing to food and body preoccupation, repeated cycles of weight loss and regain from other personal health goals and wider health determinants, reduced self esteem, eating disorders, other health decrement and weight stigmatization and discrimination”. Tylka et al., (2014) express concern about what they call a ‘learned sense of helplessness’ in which the practice of healthy behaviours can come to be seen as futile when weight is not lost as a result. This helplessness often means people do not maintain healthy lifestyle changes such as improved nutrition and exercise.

Those who do not support the traditional approach to weight and health have also suggested there is underlying political maneuvering that supports the promotion of weight loss as a broad-based prescription for health. It is compelling to consider how much of the alarm about the so-called ‘obesity epidemic’ is motivated by actual concern of health outcomes, or to what extent the ‘fight against obesity’ is a strategy to create a repeat consumer base for the fitness and beauty industry. As Campos, Saguy, Ernsberger, Oliver, and Gaesser (2006) suggest, “the current rhetoric about an obesity-driven health crisis is being driven more by cultural and political factors than by any threat increasing body weight may pose to public health.” (p. 55).

**The emergent approach: Health at Every Size®.** Over the past few years, an alternative approach to weight and health has emerged. Often described as a ‘weight-neutral’ approach, or Health at Every Size® (HAES), this emergent weight-neutral way
of looking at weight and health has evolved out of critical analysis of obesity science and recognition that diet and exercise can have a positive impact on health, independent of weight loss (Bacon, 2008). A central feature of this emergent weight and health paradigm has been ongoing feminist analysis of the traditional weight paradigm and an exploration of the impacts of the pressures facing women to look like the thin ideal (Chrisler, 2012; Farrel, 2011; Fikkan & Rothblum, 2011).

Health at Every Size® “is based on the simple premise that the best way to improve health is to honour your body by adopting healthy habits for the sake of health and well-being, rather than weight control” (Bacon, 2010, p. 277). Principles of this framework include accepting and respecting the natural diversity of body sizes and shapes, eating in a flexible manner that values pleasure and honours internal cues of hunger, satiety, and appetite, and finally, finding the joy in moving one’s body and becoming more physically vital.

Looking again at the four paradigms outlined in “From Weight to Well-Being” (Daghofer, 2013) the Health at Every Size®, or weight-neutral approach to weight and health, is reflected in the third and fourth paradigms. Paradigm Three emphasizes attaining the best weight possible while optimizing psychological and physical health for adults. This is based on the increasing body of evidence that, for some adults, health can be improved through healthy eating and exercise, with little or no resulting weight loss (Bacon, 2011; Campos et al., 2006). Health at Every Size® initiatives are grounded in health promotion principles oriented towards well-being and empowerment, promoting mental and physical health for people no matter their weight, size or shape. Sustainable health behaviours are emphasized, including intuitive eating (eating based on hunger and
satiety cues) and enjoyable leisure and physical activity (Daghofer, 2013).

Paradigm Four within the “Weight to Well Being” framework is described as “moving beyond the individual level to act on the broader socio-environmental context to promote positive mental health and physical well-being, with a goal of promoting flourishing in mind and body for all” (Daghofer, 2013, p. 6). This approach is described as opening opportunities to address a number of pressing health and social issues including but well beyond, weight-related issues. While the authors recognize it is a challenge to mobilize and coordinate the many resources required to tackle an ‘obesogenic’ environment, this is recognized as a promising way to improve the health of the entire population (Daghofer, 2013).

**Weight Stigma**

Weight Stigma, or the oppression of people based on body size, is described as being so common, so ingrained into the fabric of western society that the reality of it is rendered invisible (MacInnes, 1993). Weight stigma is thought to be a result of entrenched dichotomous thinking, manifesting in the belief that ‘fat is bad’ and ‘thin is good’ and anyone who is not thin is fat (Chrisler, 2012). Weight stigma literature describes many widespread negative characteristic attributed to fat people including: laziness, lacking motivation or discipline, less competent, non-compliant and sloppy (Puhl & Heuer, 2009). These assumed attributes allow for a climate of oppression of fat people, a “fear and hatred of fat that results in discriminatory practices” (MacInnes, 1993, p. 947). Fat people have acknowledged and measured inequities in the areas of employment, education, relationships, and health. Fat people are less likely to access secondary education, they earn less money than their thinner counterparts, are less sought
after as romantic partners and have more negative health outcomes (Fikkan & Rothblum, 2011; Saguy, 2012).

In terms of negative health outcomes, research suggests weight stigma is a significant contributor to ill health for larger-sized people. Internalized weight stigma is known to cause stress, and have a negative impact on self care and healthy lifestyle habits. After controlling for direct affect of body size, weight stigma has been shown to negatively impact psychological functioning, body satisfaction, eating and exercise habits (Mulherin et al., 2013). Some theorists suggest that weight stigma has a greater impact on fat people’s morbidity than accumulated adipose tissue (Puhl & Heuer, 2009). In other words, the societal negative view of fatness contributes more to the ill health of fatter people than the actual adipose tissue on fat people’s bodies.

This thesis research has a particular focus on fat women’s interaction with the healthcare system in Saskatchewan, and thus it is important to consider the attitudes and behaviours of health care providers towards people considered ‘overweight’ or ‘obese’. Those who provide health care services do not live in a vacuum and are not immune to negative stereotypes attributed to fat people and societal standards of beauty (Drury & Louis, 2002: Mulherin et al., 2013: Sabin et al., 2012). Fatter patients often have negative qualities such as ‘weak-willed’, ‘lazy’ and ‘non-compliant’ attributed to them by their healthcare providers, (Mulherin et al., 2013) and are “frequently berated about their weight and treated disrespectfully by their physicians” (Drury & Louis, 2002, p. 555). A growing body of research is showing that for fatter people a “perceived message of ‘blame and shame’ is at least partly responsible for the increased levels of health care avoidance seen in larger-sized populations” (Forhan & Salas, 2013, p. 206).
According to Drury and Louis (2002) and Ferrente et al. (2016), weight bias in health care provision can have a negative impact on the health of fatter people because it can impact frequency, quality and appropriateness of health care received. Women who are considered overweight or obese may delay or avoid health care completely if they have been berated about their weight, or if they feel their healthcare provider has a negative attitude about weight (Drury & Louis, 2002; Sabin et al., 2012). Drury and Louis highlight studies showing “overweight women are significantly less likely to report annual pelvic examinations, clinical breast examinations, and mammograms than average weight women” (p. 555). When asked about the lower levels of accessing health care services, people identified as overweight have cited reasons such as; embarrassment about weight, knowing they would be weighed, and waiting to lose weight before seeing physician. Thus, their reluctance to access healthcare can increase as body weight increases and the fatter someone is, the less likely they are to access primary health care services.

Weight bias in health care provision may result in erroneous assumptions that presenting health problems can and should be solely attributed to how much the client weighs. Frequently ‘obesity’ is the automatic and all-encompassing diagnosis for many presenting health concerns of fat people. Ferrente et al. (2016) suggests fat people often feel stigmatized when healthcare providers "assume that their presenting health problems are due to weight" and find themselves diagnosed with obesity before thorough medical histories, physical exams or diagnostic testing is undertaken. As suggested by Drury and Louis (2002), fatter patients often find their doctor or healthcare provider will not look further than their body size when seeking treatment. This pattern of a default obesity
diagnosis for fatter patients results in many instances of untreated or misdiagnosed illnesses, increasing morbidity and mortality rates for this population (Drury & Louis, 2002).

Fatness also has the potential to be medically stigmatizing, in that obesity can be considered to be caused by “failures of the individual” to take proper care of their health and control their food intake (Drury & Louis, 2002). Those who work in the healthcare field report assumptions of fat people including: “lazy, unmotivated, with limited intellectual ability and willfully non-adherent to recommendations” (Forhan & Salas, 2013, p. 206). Other recorded impacts of physician weight bias include: less time spent with obese patients, reduced engagement in discussions, provision of less interventions, avoidance of carrying out of preventative health screening (Forhan & Salas, 2013).

**Fat and Feminism**

Scholars suggest broad-based agreement amongst feminists that fat oppression and weight stigma are feminist issues but not all feminists approach the impacts of fatness on the lives of women in the same way (Saguy, 2012). Particular views are shaped by the paradigm of weight and health that any particular feminist resonates with (Saguy, 2012). Ideas of weight and health aside, most feminists agree that the thin ‘ideal body’ is a sexist construct that serves to control women (Fikkan & Rothblum, 2011; MacInnes, 1993; Wolf, 1991). The far-reaching impact of weight stigma and fat oppression have negative impacts on both men and women, as men also face increasing pressures to conform to a thin and muscular ideal. However, feminist scholars such as Chrisler (2012), Fikkan & Rothblum (2011), Saguy (2012), and Wolf (1991) argue that weight stigma continues to have a particular impact on women who pay an emotional, psychological
and discriminatory price for their fatness that men do not.

One possible reason for this difference in how weight stigma impacts men and women is that the current beauty ideal for women has evolved from an ideal into a beauty standard, one that all women are expected to be working to achieve (Chrisler, 2012). While the ideal for men has also become more exacting and harder to achieve, men do not face the same level of expectation in achieving that ideal (Chrisler, 2012). Men appear to be more able to compensate for failings in their level of attractiveness/thinness with other attributes (Saguy, 2012), and do not pay the penalties that women pay in their educational and employment achievements because of their fatness. In addition to increased vulnerability to verbal and physical aggression, fat women face disadvantages in education, employment, relationships, healthcare, and media representation (Saguy, 2012; Fikkan & Rothblum, 2011).

Being fatter correlates with less success in educational attainment and consequently a lower socioeconomic status for women (Fikkan & Rothblum, 2011). Social stigma and its emotional consequences, alcohol and drug use, and less financial support from parents contribute to this inverse relationship between body weight and educational attainment of fat women (Fikkan & Rothblum, 2011). Although fat men also face barriers to employment, these barriers arise at higher weights for men than women. For those who do gain employment, fatness still has a negative impact on earning power, with ‘non-obese’ women earning 17.51% more than their fatter counterparts. Fat men do not face a similar discrepancy in their earning power compared to ‘non-obese’ men (Fikkan & Rothblum, 2011, p. 4).

Finally, women are more likely to face discrimination in health care settings with
an increased likelihood of being diagnosed as ‘obese’ than are men at the same weight (Saguy, 2012). Overall, women are held to a greater accountability for their own health (and the health of their families) because of gender norms in which women are socialized to care about and take a more active role in health. As a result, women are held more personally accountable for their size and shape, and that of their family (Chrisler, 2012,).

**Struggles within the feminist movement.** In the early years of the feminist movement there was a lack of discourse on the issue of fatness through a gender lens (Farrel, 2011). Farrel (2011) notes as the fight for women’s suffrage raged in the early 19th century, both the suffragettes and those against votes for women published unflattering ‘fat’ images representing their opponents in political cartoons as an attack tactic.

It wasn’t until the second wave of feminism in the 1970’s when Susie Orbach’s ground-breaking work “Fat is a Feminist Issue” opened up the discussion of women and fatness and set the tone for early feminist thinking about fat, oppression and health. Orbach (1998) pathologized excess body fat in her framework. Women are fat, she argued, because they overeat as a response to their oppressed state within patriarchy. Orbach theorized women who broke free of patriarchal restrictions would, in turn, not overeat and return to a thinner, and presumably healthier body weight.

During this time, it appears feminist scholars were reluctant to study the lived experience of fat women and defend their civil rights (Chrisler, 2012). This resistance was likely due to an ingrained cultural belief that appearance, especially body size is something women have control over and can change, unlike other oppressions such as race or disability discrimination (Chrisler, 2012). Thus, as much as it was recognized
that fat women were treated unfairly, the underlying belief that women who were fat could become thin if they tried hard enough cast fat women as responsible for the discrimination they faced, even within feminist circles.

The third wave of feminism emerged in the 1990’s and is noted for an emerging emphasis on organizing young feminists (Orr, 1997). Orr (1997) suggests the resurgence in feminist thought can be attributed to critiques of the second wave by feminists such as bell hooks and Audre Lourdes. She refers to a “calling for a new subjectivity to a movement that had, to that point been white, middle class, first world feminism” (p. 37). During the third wave of feminism women became increasingly cognizant of the impacts of body shame and weight stigma and sought to understand the deep and profound oppressiveness of the increasingly harder to achieve beauty ideal (Wolf, 1991; Cooper, 2010). Many feminists began to speak out against the thin ideal and body shaming. The third wave of feminism facilitated a more radical view of body acceptance and has begun to provide a space for many feminist scholars to explore the assumed unhealthy fat body and challenge the traditional paradigm of weight and health.

The traditional approach to weight and health posits a distinct and causal relationship between eating, weight and health and is presented as a ‘collection of uncontestable truths’ which have become a moral code; a basis for determining someone's character (MacInnes, 1993). The feminist challenge to the traditional approach to weight and health starts with an identification and critique of the patriarchal norms and values inherent in science and medicine. Cloaked in what MacInnes (1993) calls the ‘myth of objectivity’ these norms and values can be seen to perpetuate patriarchal ideology within science and medicine. Feminists scholars have discovered
when studies control for factors such as activity level, yo-yo dieting, use of diet supplements, etc. they do not as readily support the accepted causal relationship between weight and health (MacInnes, 1993). Armed with this new knowledge, many feminists now urge an unpacking of the ‘uncontestable truths’ and demand a new way to look at weight and health (MacInnes, 1993; Saguy, 2012).

Today, there continues to be different points of view on the issue of weight and health within feminist circles. Not all feminists are aligned with the emergent weight-neutral approach to health, with many resonating more with the traditional approach. Feminist discourse within the traditional approach to weight and health often includes critique of body shaming and size-based discrimination alongside the traditional paradigmatic view that women who are over a certain size (whether determined by BMI or some other base of judgment) are at risk for increased morbidity and should pursue weight loss for health reasons (Saguy, 2012). These feminists work within the ‘obesity epidemic’ framework and have argued that a shift to a weight neutral approach to health would be doing women’s health a disservice (Yancey et al., 2006). Many feminists within the traditional approach to weight and health urge analysis of socio-economic structures that are thought to contribute to the ‘obesity epidemic’, such as lack of access to healthy foods and recreation for those living in poverty (Probyn, 2008).

**Summary**

This literature review examined the different approaches to weight and health in Canada, from the traditional approach to an emerging weight neutral approach known as “Health at Every Size®”. The argument for a shift from the traditional approach to a weight neutral approach includes a critical analysis of weight science suggesting when
variables such as metabolic fitness, exercise, diet quality, etcetera., are controlled for, the rationale for suggesting a causal relationship between fatter bodies and negative health outcomes is greatly reduced and in many cases disappears completely (Bacon, 2010; Campos et al., 2006).

The second theme addressed in the literature review, explored weight stigma and its impacts on the lives of fat people with specific reference to the impact of weight stigma within the healthcare field. The ill-effects that weight stigma has on health prompts consideration as to whether weight stigma has a greater impact on fat people’s morbidity than accumulated adipose tissue (Puhl & Heuer, 2009). Consideration of weight bias in health care is essential when it can impact frequency, quality and appropriateness of health care received by fatter people.

Finally, I reviewed literature on feminism and fatness to understand the gendered perspective on the issue of weight and health. Although a serious issue for both men and women, a gendered lens is warranted in an exploration of weight and health as weight stigma has a particular impact on women who pay an emotional, psychological and discriminatory price for their fatness that men do not (Pederson et al., 2013). As noted earlier there is a lack of literature exploring the lived experience of women who are fat in accessing the health care system. This study was designed to help fill the gap by accessing the wisdom of women who have the lived experience of accessing health care in Saskatchewan while living in a fat body. The next chapter will outline the design and methodology employed to achieve the stated study goals.
Chapter 3 - Design and Methodology

Introduction

The importance of stories cannot be understated for the role they play in “shedding light on the issue being explored” (Creswell, 2013, p. 147). The research question asks: “What are the experiences of women who identify as ‘fat’ or ‘overweight’ in accessing healthcare in Saskatchewan? The goal of this research is to provide an opportunity for an in-depth exploration of the stories of fat women accessing health care in Saskatchewan. An identified gap in the literature suggests a need to explore this phenomenon from women’s lived experience, in their voice. Burgard (2009) discusses a lack of research on factors that support long-term engagement in healthy behaviours; Puhl & Heuer (2009) call for more efforts to understand how fatter people perceive the care they receive. A particular gap in the literature addressing the attitudes of social workers in regards to working with larger-bodied clients was noted by Lawrence, Hazlett and Abel (2012).

A qualitative inquiry addressed the research question and supported the research goal of understanding the experiences of women who identify as ‘fat’ or ‘overweight’ in accessing healthcare in Saskatchewan, as it allowed for complexity in the phenomenon being studied and provides the space for emergent theories and hypotheses. “Qualitative researchers avoid simplifying their social phenomena and instead explore the range of behaviours and expand their understanding of the resulting interaction” (Glesne & Peshkin, 1992, p. 7). A qualitative approach was also congruent with my ontological and epistemological orientation, offering me an opportunity to explore the impacts of existing beliefs of fat and health in depth.
The design and implementation of this study was informed by a material-realist ontology, a view of the world that allows for multiple realities and multiple truths shaped by factors such as race, class, gender, age (Mayan, 2009). The epistemology that I embraced is subjectivist, in that I acknowledged that I cannot remove myself from being in relationship with the research participants, and that within the context of this project the closeness of relationships must be made explicit. The aim of this research was not to produce a ‘truth’ about the experience of fat women pursuing health, but rather to explore the coherence within the stories on a global, local and thematic level (Riessman, 2008), with an aim of generating more questions for exploration.

This subjectivist ontology was also a good fit with my feminist worldview, in which the personal struggles of women coping with weight stigma is considered tied to the collective struggle of women for equality. A feminist theoretical lens suggested an exploration of the unequal nature of reality, which presented in this case as an exploration of the social position and gender inequity of women accessing health services while living in a fat body. A feminist theoretical framework provided the opportunity to challenge the predominant model of viewing women who are larger-sized as diseased in which pathologizing terms like ‘Body Mass Index’ (BMI), ‘overweight’ and ‘obese’ are used to described women’s bodies.

Narrative Inquiry

Narrative inquiry is a method within qualitative research that represents the “experiences as expressed in the lived and told stories of individuals” (Creswell, 2013). According to Creswell (2013), elements or defining features of a narrative study include stories of individual experiences that may shed light on identity, utilization of many
different forms of data, use of a chronology for data analysis, examination of turning points and an analysis of context (places and situations). Use of this method was an opportunity for in-depth analysis of any one person’s story to the extent that their story can be considered to represent a larger collection of social experiences (Mayan, 2009, p. 49). While not suggesting generalization to the rest of the population, stories have an important social role, and are “connected to the flow of power in the wider world” (Reisman, 2008).

This study provided an opportunity for me as the researcher and the participants to make meaning of the participant’s experiences accessing health care in Saskatchewan, providing insight into what it might be like for other fat women. Conversely, a narrative method can also illustrate how larger social structures can influence individual consciousness and identity (Riessman, 2008), allowing an exploration into the cyclical nature of oppression and how culture-based biases become internalized.

There was a fit between narrative method and social work practice, both of which have a focus on client’s stories and giving voice to marginalized groups through listening to their stories (Larsson & Sjöblom, 2010). It is worth noting Reisman’s (2008) caution that we cannot truly ‘give voice’ to research participants, acknowledging the researcher’s role in recording and interpreting stories (Larsson & Sjöblom, 2010). However, this research can be a leverage point to initiate further exploration, as narrative method is appropriate to ‘break open’ a topic and provide a “description of the phenomena when all of its contradictions, messiness and depth is (re)presented” (Mayan, 2009, p. 11).

Participant Recruitment Strategy

Prior to participant recruitment, ethics approval was obtained from both the
University of Regina Research Ethics Board and University of Saskatchewan Research Ethics Board (see Appendix 3a and 3b). Ethics approvals were sought from the University of Saskatchewan in addition to the University of Regina because the study recruitment strategy included advertising on the University of Saskatchewan campus.

According to Creswell (2013) the population sample for qualitative research using narrative methodology is research participants who can best inform the research question. Other important considerations include distinctiveness, accessibility, and willingness to provide information (Lincoln & Guba, 1985). With these considerations in mind, the sample for this study was adult women (over 18 years of age) who live in Saskatchewan, self identify as ‘fat’ or ‘overweight’, and who have had interactions with the health care system. Targeting adults simplified issues around informed consent and ensuring understanding by the participants of possible emotional triggers that may arise from discussions about weight and health. Exclusions for this project were people with a close previous relationship with the researcher including family members, friends and close colleagues as well as clients or former clients of the researcher. Another identified group excluded from the study were people with a disclosed diagnosed appearance related disorder such as anorexia, bulimia or body dysmorphic disorder. The subject matter of the project is one that may be particularly disturbing to people with these diagnosed conditions, so this exclusion was added to ensure risks of participating in this project were minimal.

The study parameters were kept to participants who live in the province of Saskatchewan because health services in Canada fall within the scope of provincial governments, and therefore any potential follow up research, or change to practice would
likely be provincial in scope. Further, keeping the participants restricted to only those who reside in the same Saskatchewan city as the researcher allowed for ease of access to a face-to-face interview. In this type of study, where the participant is requested to share in-depth and potentially painful stories with the researcher, in-person interaction was determined preferable because of the importance in building rapport and trust. People are less likely to share in-depth stories of their lives when trust is not established first. Finally, I selected these geographical parameters as, at the time the study was conducted Saskatchewan was my home, allowing me to make use of my personal understanding of the local and provincial health care system in providing context for data analysis.

In order to access a population of women who self-identify as ‘fat’ or ‘overweight’, and who have had interactions with the health care system a purposive sample was acquired using a snowball method. First, informational posters (see Appendix 1) were drafted that described the aim of the research, the population being recruited, and affirmed confidentially. Potential participants were invited to contact the researcher if they had any questions about the process, and a phone number and email address were provided. This informational poster was shared electronically through the professional and academic networks of the researcher including email and social media distribution. Social media distribution included sharing the poster on Facebook groups such as the Saskatoon Saskatchewan Association of Social Workers (SASW), Fat is a not a Four Letter Word (a local group of body positive activists).

Initial contact with potential participants was conducted via telephone conversation or social media messaging, depending on individual preference. During this initial contact potential participants were screened for the study parameters, such as described
above (location, age, etc.), but also for willingness to share their stories. Time was taken to review the study purpose, requirements, and expectations on both the part of the researcher and the participant. Also during this initial conversation allowed for discussion about potential costs, benefits and risks for the participant of engaging with the project. Parameters of confidentiality and anonymity were discussed and the voluntary aspect of this project was highlighted with the participants.

Those who met the study criteria (i.e. over eighteen, self-identify as ‘fat’ or ‘overweight’) and were interested in voluntarily participating, were invited to a face to face interview, scheduled at convenient time for both the researcher and the participant.

Data Collection

The study sample was comprised of three female participants. To reflect the data requirements for a narrative methodology, in-depth stories from all three women were collected and analyzed. The decision for a small study sample was informed by Creswell (2013), who suggests keeping the number of participants low in studies such as this one where extensive data is collected from each participant. This data was generated through in-depth interviews with women who self-identify as ‘fat’ or ‘overweight’ and have had interaction with the health care system. The choice to have women self-identify as ‘fat’ or ‘overweight’ rather than being required to fall into a pre-determined weight category is congruent with a feminist perspective of women having the best knowledge of themselves, rather than relying on an pre-existing classification such as the Body Mass Index (BMI).

According to Creswell (2013), face-to-face interviews provide the best opportunity to build rapport and trust with the research participants, which is vital when engaging in
in-depth exploration of a potentially painful topic. The interviews took place in a space chosen by the participants and that offered comfort and safety. They ranged from 60 to 180 minutes in length, ensuring time for building rapport and exploring participant stories in depth without over-burdening the participants with excessive demands on their time. Prior to the start of the interview, participants were provided a consent form (Appendix 2) that the researcher reviewed with them, highlighting the participant’s right to engage at a level in which they are comfortable, and to end the interview at any time. The participant’s right to withdraw from the study at any time was also confirmed. In order to help build rapport and to provide a framework for the discussion, participants were once again informed about the purpose of the study, why they have been chosen to participate, and were assured of confidentiality (Creswell, 2013). A semi-structured interview guide was used, providing topic areas and questions relevant to the research question (see Appendix 4). Interviews were audio-recorded using a digital recorder along with supplemental hand-written notes that I took. These recordings were transferred to my computer as soon as possible after the interview and deleted from the recording device. The computer was a private use computer, protected with a passcode to ensure no one else had access to the data files (both audio and text).

Reflexivity was an integral part of both maintaining proper boundaries throughout the study and in collecting and analyzing data. In order to maintain appropriate boundaries and keep track of my own thoughts and feelings a reflective journal was used throughout the interview and data analysis process. Reflective journaling included a post-interview process where I considered questions such as; a) how did I relate to this story? b) what was similar to my story? and c) what was different?
Each participant was asked to commit to a maximum of two interviews. At the interview, each participant was presented an honourarium of fifty dollars to recompense them for their time and effort.

**Data analysis procedures.** The interview recordings were transcribed verbatim as soon as possible after each interview, allowing for an initial reflection on the data. Each participant was assigned a pseudonym. A combination of thematic and structural analysis of the data was undertaken to engage in a comprehensive understanding of both the data content (thematic) and the context (structural) based on the approach to data analysis offered by Riessman (2008). Thematic analysis has a focus on the content of the data, attention being paid to what is said, rather than how, why, to whom and for what purpose. Structural analysis shifts from the content to the form of the story. This includes how the story is told, by whom, where and other details that set the stage and provide context for the data. Combining these two methods provide an in-depth understanding of how the narrative was shared, to whom and for what purpose (Riessman, 2008). A Three-Dimensional Narrative framework was employed for the structural analysis. According to Clandinin and Connolly (2000), these three dimensions are: “the personal and social (interaction) along one dimension; past, present and future (continuity) along a second dimension; place (situation) along a third dimension.”

Each story was considered initially on its own, organized and re-ordered into a chronological account. In thematic analysis each narrative is carefully examined for underlying assumptions, which are named and coded (Riessman, 2008). To this end, each transcript was carefully reviewed and notable experiences or characteristics were coded and noted as ‘refrains’ within the analysis. These refrains provided a framework to
consider the experience of each individual woman, which were explored in-depth. Patterns were looked for and compared within the narratives, and a sorting process was undertaken with the refrains from all three participants and incorporated into a broad-based thematic analysis, resulting in the identification of six themes common to the experiences of all three women. The narratives were constructed within the framework of a Three Dimensional Narrative Analysis defined by this three-dimensional space: studies have temporal dimensions and address temporal matters: they focus on the personal and the social in a balance appropriate to the inquiry: and they occur in specific places or sequences of places (Clandinin & Connelly, 2000).

**Ethical Considerations**

Developing and adhering to strategies during the research process for protecting participants from harm and ensuring confidentiality is an ethical priority. Prior to proceeding with the study an ethics protocol was submitted to and approved by the Universities of Regina and Saskatchewan Research Ethics Boards for review and approval, providing potential participants assurance that the researcher is following best practice guidelines. The consent form outlined the study purpose and the steps taken to ensure participant’s confidentiality and anonymity.

My role in ensuring confidentiality related specifically to the data included safe storage of the audio-recorded interviews. All research files were kept on the researcher’s personal computer that was private and password protected. The computer was stored in a locked cabinet in a locked office. Only the researcher and her thesis supervisor had access to the raw data. Hard copies of data are stored in a locked file cabinet in the supervisor’s office for a total of five years, at which point the data will be destroyed.
Participants were not identified by name, and instead referring by a pseudonym and I was the only person with access to the master list. I also adhered to my professional Code of Ethics throughout the study (Canadian Association of Social Workers [CASW], 2005). Any questions regarding procedural steps were fielded to my supervisory committee and to the Research Ethics Board at the University of Regina.

Two areas for ethical concern that can arise in a project such as this are impact of the research process on the participant and accurate collection, analysis and reporting of the data. A narrative methodology necessitates in-depth exploration of a topic and for the women participating in this study; exploration of potentially painful memories associated with weight stigma and health may result in resurfacing of negative feelings about the body. The participant(s) put themselves in a place of sharing intimate aspects of their life and private health details with the researcher. A perceived power imbalance between the participant and the researcher could put the participant in a place of feeling obliged to divulge information they may not wish to share. Additionally, the process of data collection and analysis also brings potential to misrepresent, distort or delete findings that have been provided in good faith by the participants (Larsson & Sjöblom, 2010).

A variety of strategies were engaged to address these potential ethical issues. Preparing the participants for the interview process included facilitating an understanding of informed consent and the implications for participation, degree of risk, and the steps the researcher has taken to ensure anonymity and confidentiality. It was made clear that the participant was under no obligation to answer any question and could withdraw from the study at any time. In order to address potential perceived power imbalances, I addressed the issue directly with the participant(s), emphasizing my feminist approach to
social work in general and this study in particular and what that meant in terms of my values around shared power. Should participants had found the research process had triggered negative emotions to the point of needing support beyond the scope of the researcher/participant interaction, I was prepared to offer referral to a variety of agencies and programs (see Consent Form, Appendix 2). I am also a practicing social worker, with active membership in the Saskatchewan Association of Social Workers and engaged in this research in ways I believe were in alignment with my professional code of ethics.

Additional strategies were used to ameliorate possible ethical concerns when it comes to data collection and analysis. Creswell (2013) urges researchers to recognize the importance of the subjectivity of their own lens. Reflexivity entails intentional and continual reflection on the part of the researcher to be responsive to the information emerging as the research process proceeds. The implications for this study included an intentional effort on my part to reflect on assumptions, reactions and being aware of the impacts of my relationship with the participants.

**Trustworthiness**

The trustworthiness of a study relates to how much stock can be taken in the findings. Lincoln and Guba (1985) suggest asking if the findings of this study “will be worth paying attention to….is it worth taking account of?” (p. 290). Can the reader trust the credibility of the arguments and the processes? Are the findings applicable to the conversation at hand? Is there consistency? In considering the trustworthiness of a study, methodological coherence will also be considered, investigating the appropriateness of the approach and methods used in the research to reach the stated aims.
Lincoln and Guba (1985) outline the elements of trustworthiness in qualitative research as: credibility, transferability, dependability, and confirmability. Strategies to verify trustworthiness suggested by Mayan (2009) include researcher responsiveness, or the ability to adjust the project as new information emerges. Lincoln and Guba (1985) offer concrete suggestions to operationalize the elements of trustworthiness in a qualitative study. Some examples in the area of credibility include a) avoiding over-identification, keeping what they call ‘detached wonder’ and b) triangulation, which is confirming data through multiple sources, methods or theories. The journaling process was also engaged to address the issues of over-identification. In terms of triangulation this study employed the strategy of peer debriefing, in which I connected with my supervisor and a colleague to reflect on the study as it progressed. This peer debriefing offered me direction and objective feedback on the study process.

Validity in this project is demonstrated by my ability to interpret and reflect the stories of the participants rather than determining the factual accuracies of the narratives. I engaged participants in member checks, acknowledging the interpretive nature of narrative inquiry. Participants were sent an inquiry email asking if they would like to read an overview of the narrative composed of their stories as well as a short summary of the thematic analysis. Two of the three participants responded by the deadline and were provided the summary and invited to provide feedback. One participant did respond with concerns about potentially identifying details of her story. These concerns were amended to her satisfaction. Attention was paid to both narrative coherence of the final narrative and pragmatic use of the data, for instance to determine if it can be used as a base to build knowledge (Riessman, 2008). This was mostly seen in the decisions where to cut or trim
participant’s stories to provide both balance among the participant's stories and produce a manuscript of a reasonable length.

**Summary**

This chapter began with a description of the rationale for using a qualitative, specifically a narrative, methodology for this research. The impact of story-based research is explored as well as the resonance between the proposed methodology and social work values and goals. Next I reviewed the study sample size and how it was determined as well as study participants characteristics, including characteristics that excluded potential participants (relational, geographic, etc.) from the study. A description of how participants were recruited and the research process is provided including the interviews set up, timeframe, etc.

The next sections offer a description of the analytic process, how I engaged with the data in order to make meaning of the participant's stories. As well I take some time to set the context for the participant's stories by explore the three dimensional aspect of the study. The chapter wraps up with a consideration of ethical concerns and steps that were taken to ensure no harm befell the participants, as well as an exploration of the concept of trustworthiness, discerning whether the study is sound and the data worthy of paying attention to. The participant’s stories and an overview of the thematic analyses are offered in the next chapter.
Chapter 4 - Findings

Introduction

This chapter presents the findings answering the question: *What are the experiences of women who identify as ‘fat’ or ‘overweight’ in accessing healthcare in Saskatchewan?* The stories of three women who participated in this research project are shared here. I begin with an overview of each of the three participants that includes background details of their lives and health status and engagement with the health system. These background narratives are arranged chronologically and include other elements such as place, time and relationships to provide a three-dimensional context for their stories. Additionally, the history offered by the participants was included to provide an opportunity for greater understanding of each participant’s story from their point of view, to honour as much as possible the wisdom learned from life experience, as a feminist theoretical lens would suggest.

Following the retelling of participants’ stories there is a discussion section exploring the patterns and meaning within their stories. The chapter ends with an exploration of the central emergent theme called The Journey. Fictional names of Jane, Mary and Ellen are use to protect the participant's identity.

**Setting the context: three-dimensional narratives.** According to Clandinin (2000), a three dimensional narrative is one that pays attention to three different dimensions within the story, 1) Place / Situation, 2) Temporality (Past, Present Future) and 3) Interaction (Social). What follows is an overview of these three dimensions that set the stage for the stories of the participants.
The interviews for this research project were conducted in late 2015, from October to December in a large city in the province of Saskatchewan. Predominant is the traditional view of weight and health based on the normally unchallenged correlation between higher body weight and negative health outcomes; fatness is pathologized by the use of medicalized terms like ‘obesity’ and is considered a ‘chronic disease’. The Health Region in the community where the participants live offers programs to support adults and children deemed ‘obese’ to lose weight ("LiveWell Chronic Disease Management, Obesity" n.d.). This is important because knowing how healthcare professionals perceive the relationship between weight and health helps us understand the motivations of healthcare professional.

Saskatchewan's political climate in the fall of 2015 is characterized by healthcare deficits and threats of impending austerity based healthcare cuts alongside the ongoing implementation of LEAN as a basis for health care management. LEAN is described as “a patient-centered approach that helps employees, physicians, patients and families work together to find ways of improving processes and eliminating waste so that everyone receives reliable, safe, timely, high-quality health care" ("Saskatchewan HealthCare Management System. Frequently Asked Questions" n.d.). The potential impact of these factors on relationships between healthcare providers and patients must be considered, particularly the capacity of health care providers with deeply ingrained prejudices to respond to patients who may be seen as less compliant and therefore wholly culpable in their own ill health, such as fat people.
The Stories

Jane

Jane's background narrative. Jane is a forty-eight year old woman who lives with her husband and three children. Born into a farming family, she remembers being healthy and active as a child, and doing lots of physical work on the farm. Jane muses that despite an outdoor, hardworking lifestyle, larger bodies are common in her family. As a child, she recalls she was "teased relentlessly for being fat and overweight." A particularly significant event of Jane’s childhood occurred when she was in grade nine when her parents, in an effort to reduce Jane's weight, paid for her to go on a very low caloric diet, supplemented by injections of pregnant horse urine. This regime did result in a drastic weight loss, however Jane says it was quickly regained.

Teen years. During her teen years, Jane says her self-esteem had been damaged by her father who repeatedly told that she was "ugly, stupid, and fat". She internalized the negative messages from her father and she found herself in a relationship with an abusive boyfriend. Jane also demonstrates inner strength and fortitude, and although her life is a tough one, she was not cowed by the abuse and was able to leave her boyfriend and begin a life with a supportive and loving partner.

Also significant at this point in Jane's life is her employment as a First Responder. This job played a significant role in how Jane perceives herself and how she, as a larger-sized woman, will understand her experience accessing healthcare. She says her job as a First Responder offered her an 'insiders view' into what she perceives as negative attitudes and perceptions of healthcare workers towards fat people. As a First Responder she experienced the discomfort of hearing coworkers speak and act negatively toward the
fat people in their care. Jane experienced this even though she herself is fat, and theorizes that her fatness becomes invisible (or less visible) to her coworkers as they get to know her and develop a working bond with her. She reflects on an inner shift that occurs during her time as a First Responder which she goes from being in a position of observing the stigmatizing and oppressive behaviours in her co-workers towards fat patients to later on in her life when she becomes the 'fat patient' herself.

Adult years. Jane's early adulthood is marked by many stressful and unhappy circumstances including the death of her mother, working as a First Responder, struggles with fertility, living in poverty, diabetes and depression. She links her poverty and her pregnancies with a change in her body. When Jane was thirty-seven, she got a referral to an orthopedic surgeon, but was denied treatment, due to her size (see The Orthopedic Surgeon story). Jane started to feel frustration at how doctors talk to her about her weight and focused on it for every presenting issue.

In her mid-forties Jane was diagnosed with a severe chronic pain condition that she says has had a huge impact on her quality of life. Jane shares that a year or two before being diagnosed with this condition, she agreed to put her name on a wait list for bariatric surgery (a stomach reduction) at the suggestion of her doctor in the hopes of a reduction in her weight. She says at the time she was uncertain if she was interested in having the surgery, but her doctor was in favour of the idea and she thought it couldn't hurt to have her name on the list.

Upon officially entering the bariatric program, Jane reflected on the change she perceived in the attitudes of health care providers. She says that immediately she received positive feedback from practitioners and encouragement for 'doing something
about it’. Jane also noticed that healthcare providers did not focus as much on her weight in their interactions. Jane expressed frustration that all the efforts she had made over the years for her health had seemed disregarded and this drastic step of surgery was the only way to get support/approval from those providing health care."...even though, at other times I said 'well, I'm trying...I'm watching my diet and I'm trying to do as much as I can..' That didn't matter because it didn't show up...

Jane told me she seriously reconsidered having the surgery, but was strongly urged to stay in the program by her healthcare providers. In the end, she did decide to go ahead with the surgery because, she told me, she was assured it would eliminate the need for her to continue taking medication for diabetes and high blood pressure, reducing the stress on her system. The lack of weight loss since the surgery is causing Jane concern because she says that in the week after our interview she has her 1-year post-op check up. She is further worried because her diabetes has again become problematic, and with her re-injured ankle, and the stress from the nerve pain she has regained four pounds. She says she is 'scared spitless' about the appointment. "It makes me feel afraid! Because I know they're gonna be....critical... They're not gonna look at the positives, that I have done!" Jane acknowledged this fear has kept her from seeking healthcare in the last few months as she her diabetes has flared up.

**Jane's health care stories.**

*Fly-ball and the Emergency Room.* When Jane is thirty-three she decides, after a period of inactivity, to make a return to a much beloved activity of fly-ball with her dog, which Jane says is one of her favourite ways to be active. Unfortunately, Jane underestimated her dog’s level of excitement to be at fly-ball again, and was not quite
prepared for a sudden leap forward, yanking Jane off her feet and crashing them both into a fence. She states:

He literally pulled me right out of my...right out of my skin, pretty much, right?

And so, as I went flying through the air, I did two and a half somersaults through the air until I landed. And my, like I mean I took down all the fencing as I was kind of flying between the leash, and...so I was pretty scraped up. Like and ah, hurt, like I mean there are other parts of my body that were pretty hurt, not just my ankle, I mean my ankle was the worst. Like and if you've ever done fly-ball, or seen fly-ball, it's not a quiet place. And yet, there wasn't a dog barking. And I think that's one of the things that scared me the most, is the fact that it was completely silent (laughs) as I landed.

Jane was badly scraped up and injured and was taken to a local Emergency Room (ER). Unfortunately, this was not a positive experience for her and she tells me "they just...totally...um...were rude! Like the whole experiences, like the nurses, like you know, like, um, it was a bad experience from the time I walked in." As the ER visit continued, Jane said the nurses maintained their brusque attitude with her, which included commentary and judgment about her weight. She remembers comments like, "well, you know...when you're heavy you fall harder". Jane says she felt the nurses were insinuating that, 'if you're fat you kinda shouldn't be doing that stuff!'

When the doctor arrives, Jane felt there is a distinct difference in how he treated her compared to another patient, which she perceived as being not only friendly, but flirty. But his tone changes when he gets to Jane.
Not that I want him to be flirting. But he was dismissive of everything, of my injury...so then I keep questioning him and, and it's like.... But his attitude, like I just felt like because I was a heavy, fat person, he didn't take the injury seriously, that I was actually doing it in a sports, athletic....like this was a sports injury (Jane).

Jane asserted that the ER doctor did not take her injury seriously and provide the treatment she felt she would have received if she was seen as a more athletic type of person. Jane went on to say that in the interaction with the doctor, her negative experience is less about the words he used and more about the feeling she gets from the attitude she perceives, an attitude she remembers well from her days working as an ambulance attendant and that she believes her injury was dismissed and not treated because she was fat.

Discussion. In considering a three-dimensional lens (a context of place, time and interaction) to Jane's story, what first occurs to me is that Jane enjoys attending fly-ball with her dogs. The physical space of the fly ball area is a representation of the active and physical life Jane is engaged with that healthcare personnel don’t see or acknowledge due to assumptions about Jane because of her size. In her narrative, Jane does not allude to the physical space of the emergency room, and it is hard to say how much the physical location of the emergency room in this story impacts her, or the events that take place within its walls. We might assume, like most people, Jane experiences the space of a hospital as a place of stress and contributes to the power of the healthcare professionals that she interacts with there. Within her health region, it is possible that the climate of
frustration toward patients who are viewed as ‘over using’ the ER may have an impact on how the staff at the ER are treating Jane.

It is difficult to know for sure the meanings and intentions of the nurses and the doctor in this story. Jane felt that she was treated somewhat gruffly by the nurses, but was consoled by overhearing their interactions with another patient, who they were also gruff with…so Jane felt she wasn’t being treated differently. Although, the nurses did make body-shaming comments to Jane, implying she is to blame for her injury because she is fat. When the doctor is dismissive of her injury, Jane feels his attitude is unjustified because she sees her injury as serious. She believes if she had presented as someone who is more obviously active, she would have been seen as ‘justifiably’ accessing the resources of the hospital and the staff and would have more easily received the treatment she needed for her ankle.

This episode has had long term implications for Jane’s health and well-being as she feels she is no longer able to engage in physical activity as much as she would like. Jane feels the lack of treatment has had long-term implications for her mobility and her health and well-being as her ankle is weak, she has some trouble walking and is more prone to accidents/falling. The body shaming and blaming comments by the nurses in this story have contributed to Jane’s evolving sense of injustice around weight and health.

*The orthopedic surgeon.* Three years after the fly-ball incident, Jane had a referral to an orthopedic surgeon to address the ongoing issues with her ankle. Jane believes because of lack of treatment, her ankle has not healed properly, resulting in frequent falling, putting her health and wellbeing at further risk. Her hope is to finally
get the needed treatment so she can regain her full mobility. Hope is dashed as she is refused treatment because of her size.

Jane says:

Between two or three of the ligaments are completely missing, like aren't attached. And so, eventually got to see an orthopedic surgeon. … And he told me 'Yes...from what I see and what say, you need to have surgery. But, I won't do the surgery because you are too fat, and you're diabetic. And, I won't do the next set of tests, because it would be in the MRI (Magnetic Resonance Imaging) machine and you are too fat to fit in the MRI machine'.

The surgeon offered to relook at the possibility of surgery for Jane at a future date if she lost weight, which he suggested she could do with exercise. Jane expressed frustration at this because she couldn't see how she could become active enough to lose weight again with her impaired mobility.

Discussion. Jane’s interaction with the orthopedic surgeon is more straightforward and less filled with subtext than the interaction described in 'Flyball and the ER'. In this story she says she is told she does indeed need the surgery, but is simply too fat for either the surgery or for further tests. What we are seeing here is that an incident in Jane’s past - hurting her ankle and not getting the treatment she needed then, which has a continued impact on her mobility. Now, with this interaction, the continued denial of the needed treatment means she likely will continue her pattern of falling and hurting herself.

Back at the Emergency Room. This is Jane's story about a time she accessed the ER late at night due to a reaction to a new diabetes medication she was prescribed. Her pharmacist warned her she might experience side effects and indeed, Jane started to feel
very unwell and she told me her blood sugars were racing up and down. At midnight she finally asked a friend to accompany her to the ER, and here is the story of that experience in her own words:

We came to the emergency room, and ah...this is where I really recognized that attitude, you know, kinda thing? And, this doctor came up to me and, like I mean I have proof...like the heart monitor is racing one minute and down the next. Like there is obviously something causing this. And he's like 'oh, the medication would never cause that, you're just overweight and out of shape and you should be taking better care of your diabetes and that'. Like my blood sugars were up and down and up and down now too, right? And it’s like 'well that's the whole point...I'm taking care of my diabetes, I started this new medication, and here I am in the emergency room.' But he literally said 'well you're fat and out of shape and ah...you should be taking better care of your diabetes, and you have little kids at home that you should be caring for and not be doing this'. Like, what am I doing? He was just so...dismissive. And my girlfriend works in the hospital, and she's just like 'What does that even mean?' And even the nurse was just like... And then when the guy who takes my blood? Like, I've seen that - where you're just irritated that you're having to do something...like this person's just...'not really needing to be here at 2 o'clock in the morning.' He was unnecessarily rough and my girlfriend, because she works in the healthcare system, she's just like 'what is going on?' And I said 'that's the joy's of being fat'.

And I wasn't somebody that had...'cause we've been ...more poor then wealthy for most of our married lives. So I probably didn't...present as somebody that was
very...like I never had any beautiful hair. So I ...you know, I'm tired, I'm not feeling well...I'm probably in baggy mom clothes. I'm fat.... And that's the assumption.

Discussion. In this story Jane had interactions with the pharmacist, a doctor, other healthcare staff and her friend. The doctor seemed dismissive of Jane's concerns and symptoms, despite the readings of a heart monitor that Jane says ‘proves’ she was having some kind of reaction to the medication. Not only does Jane feel the doctor is dismissive of her and her concerns, she felt the doctor actively shamed her for presumably not taking 'good enough' care of her diabetes/health as well as implying she was not being a good mother because she was accessing emergency healthcare at night. In considering the context of this story, it is important to remember that the current climate of austerity and frustration toward patients who are viewed as ‘over using’ the ER in Saskatchewan may have an impact on how the staff at the ER were treating Jane.

In this story Jane had an ally, a friend who came with her to the hospital and is witness to interactions with the healthcare staff. Jane’s friend acknowledges and seemed surprised by the shaming and dismissive treatment by the healthcare staff. Jane’s rueful comment to her friend that her experience at the ER that night is one of the ‘joys of being fat’ affirms this kind of treatment is something Jane has experienced before and sees as being related to her larger body size.

Key refrains. The focus of Jane's narrative has been about her interactions with health care providers over the years, both as a result of various chronic conditions and accidental injuries. As I reviewed Jane’s transcript, I noted the most often recurring refrains to be; being dismissed or not taken seriously, being honest and challenging
health care providers, shaming or unkind treatment, the journey, fear of healthcare professionals, healthcare not provided or accessed, default obesity diagnoses.

Experiencing *shaming or unkind treatment* when accessing healthcare was a regularly occurring experience for Jane. These kind of interactions range from healthcare professionals blaming Jane's body size for an injury ("*You know when you're heavy, you fall harder*”) to feeling constantly lectured or criticized because of assumed lifestyle behaviours, such as Jane's activity level or her nutrition habits. An example of shaming or unkind treatment in a healthcare interaction was when Jane was denied access to an MRI test because (she was told) she wouldn’t fit into the machine. Another example is in the “Back at the ER” story, where Jane reflects a feeling that her presence was resented by some of the healthcare providers alongside the implication that fat patients bring problems on themselves and are a drain on healthcare resources.

Jane describes repetitive instances of receiving a *default obesity diagnoses*, in which and the only solution she is given to a health care issue is to lose weight. Her frustration with doctors not looking for other potential causes of medical concerns beyond body size was expressed by a joke she told that one day she would go to the doctor for a sore finger, only to be told the answer would be to lose weight. As her frustration builds over the default diagnoses of ‘obesity’, I noticed Jane repeatedly expressed a desire to be able to challenge health care professionals more, to not accept a default obesity diagnoses and demand further exploration be done for other possible diagnoses. She talks in awe of a friend who challenged her healthcare provider by saying “pretend I'm a hundred pounds and tell me what’s wrong with me”. She says that after being with her main health care provider for many years, she is able to sometimes
challenge him if she feels he is defaulting to an obesity diagnosis. Unfortunately she often finds herself either seeing specialists or residents who, she says, often zoom in on her weight being the problem.

 Fear of healthcare providers is another recurring refrain in Jane's story. Impacts of this fear range from increased stress experienced by Jane during medical appointments to not being truthful about her lifestyle habits when anticipating a negative reaction from her healthcare provider. Jane acknowledges at times she has avoided health care appointments out of fear, though for the most part the responsibility she feels toward her family motivates her to continue receiving healthcare.

 An unfolding story within Jane's narrative is the realization of her own journey, how she comes to an understanding of the prevalence of weight stigma in the health care she has received and how it has affected her life and wellbeing. Jane’s perception of her journey has been shaped by her view of herself as having an inside understanding of healthcare because of her years as a First Responder. When exploring this unfolding understanding, Jane talks evocatively of a window (seeing others being shamed) that turns to a mirror (now seeing herself in a similar situation), recognizing she has become 'the fat patient'.

 Mary

 Mary's background narrative. Mary is a twenty-nine year old woman living in a city in Saskatchewan with her partner. She shared with me that her life at home growing up was not stable and she often moved, sometimes living with her grandmother, and also with a foster family. Mary's health challenges began when she was quite young, having received a diagnosis of mild asthma when she was five years old. She tells me that
when she first began to menstruate, she did not have much support from her foster family to help her understand what was happening, or get the supplies she needed. This lack of support meant she had to go on her own to buy pads, which was embarrassing. It appears taking charge of her own health and well-being is a pattern that started early continues through Mary’s narrative.

Mary currently has a full time position and a casual position as a human service worker in healthcare. Describing herself as social person, she places an emphasis on ensuring she has ample opportunity to connect with family and friends, which is part of how she engages in self-care. As Mary moved into adulthood her journey was coming to understand the importance of finding a suitable family doctor (see Taking Charge - The Quest for a Good Doctor). This doctor journey happened alongside Mary's thoughtful consideration of her values and the meaning of health (see Evolving Understanding of Health).

Mary's healthcare stories.

**First doctor visit.** Mary shared the story about her first significant experience with a doctor when she was sixteen. Mary had been concerned about her irregular periods so she took herself to a walk-in clinic. Not having the support of her foster family, Mary took charge of the situation and asked a friend to come with her. The doctor she saw, without doing any kind of physical exam, quickly diagnosed Mary as 'overweight' and told her to go on a diet, lose weight, and the problem with her periods would go away. Mary became emotional when she told this story and said because of this incident, she "...had a lot of shame for a long time."
Mary says she left the doctor’s office in tears, feeling overwhelmed and without any advice on how to proceed. She came to the conclusion that dieting and trying to change her body "was her job now”. She says she simply learned to live and not talk about her irregular periods for the next few years. Mary was sparked to take charge and reengage with the medical system when there got to be a year between her periods (See Quest for a Good Doctor).

Discussion. I see Mary’s interaction at the walk-in clinic as coloured by power dynamics often found in the doctor/patient relationship. As an unfamiliar space, the physical space of the walk-in clinic, may also have shaped Mary’s experience of fear and confusion. Also, walk-in clinics are not generally known for being a place where thorough physicals are done or histories taken, which Mary may or may not have been aware of at that age. Mary’s experience at the clinic shows why she values having a family doctor that she knows, trusts, and will take the time to offer options for Mary to consider to improve her health.

Camp counselor story. Mary told a story about being a counselor at a summer camp for children with disabilities:

I worked for [children’s’ camp] when I was younger. Which is... I don't know if you know...is a camp for people with disabilities.. And there's a lot of training of around how to work with people with dignity and respect and empowering them, especially when you are in a place that has so much power. Like when you are working with someone who is in a wheelchair, who is non-verbal, who has lower mental capacity, like that is immense power... And so learning to give people as much power as you can in the moment, and one of those things is if you are
helping someone to change their clothes, saying like ‘we're going to take your shoe off this foot, okay I'm undoing your lace...." and like talking them through exactly what's happening. Doctors never frickin do that! They're like ‘spread your legs!’ and they just shove something up there, and they search around.....and they say 'wipe yourself off’.

Mary’s training at the summer camp and her interactions with the participants had a deep impact on how she perceives power in helping relationships. She learned that there is power in the role of camp counselor, especially with campers who are in need of so much help, and she learned how to be aware of and not misuse that power. Mary perceived a correlation in the power dynamic between campers and counselors alongside the power dynamic between herself as a patient and a doctor. This experience as a camp counselor shaped Mary’s expectations of what she wants from healthcare providers.

*Taking charge - the quest for a good doctor.* Mary talked about a shift that happened for her in her mid-twenties when, after noting her periods were getting to be a year apart, she decided to become proactive with her health. Mary recognized she needed to stop relying on walk-in clinics to access healthcare and began a quest to find a family doctor who would get to know her, her medical history and provide more in-depth care. Her quest for a family doctor coincided with her decision to go to university, which she says helped cultivate a critical thinking mindset.

The first family physician Mary connected with she described as condescending and ‘terrible’ with a traditional view of health and outdated ideas. She was troubled that this doctor did not perform any of the tests (like pap tests) or exams that Mary expected. This doctor also seemed dismissive of her health concerns and focused on weight loss.
After about a year with this doctor Mary decided it was time to keep looking. She engaged a strategy of looking for a female doctor, with good ratings, who was a recent graduate. Mary knew she felt more comfortable with female doctors and she felt a new graduate would not only be someone more likely to be taking new patients, but would also be open to non-traditional views of health, especially when it came to weight.

Her strategy paid off, as she reported being quite happy with the next doctor she engaged with, who is still her family physician. Although this new doctor also holds some traditional views on weight and health, she does not assume Mary’s weight is the cause of all her health problems. Mary says this doctor offers a path of exploration, with tests, exams and referrals. Mary especially appreciates how her doctor listens to her concerns and is careful to explain all that she does and why she is doing it. This new doctors’ due diligence has led to a diagnoses of Polycystic Ovarian Syndrome (PCOS) as well as the discovery of cysts on Mary’s ovaries that may be the cause of problems previous doctors attributed solely to Mary’s weight.

Feeling shamed or dismissed by a healthcare provider creates a situation where people are at-risk for, as Mary says, ignoring their health issues and not accessing health care. Finding a doctor who listens to her concerns and doesn’t automatically attribute health problems to her weight has helped foster a positive attitude toward the healthcare system for Mary. However, Mary feels her doctor is the exception, rather than the rule.

**The PCOS story.** Mary's diagnosis of Polycystic Ovary Syndrome (PCOS) is especially emotional for her because she has always had problems with menstruation, which for many years was dismissively attributed to her body size by healthcare professionals. She said she had irregular periods and complications for ten years because
she could not get a healthcare professional to do any tests or provide any treatment other than prescribe weight loss. Her current doctor interrupted this pattern and had tests done, resulting in a diagnoses of PCOS, and provided further help with a referral to a gynecologist. Here is Mary’s story of that encounter:

And so, she sent me to a specialist...gynecologist, to look more into other options that could help with the PCOS, and he was probably 70 and looked at me...said I was fat, gave me a pamphlet to lose weight. So I went 'I’m not going back to you'. Yeah...and so I started crying in his office and he's like ‘Why are you crying?’ It was like 'Thank you for being aware of the situation'...(whispers 'no you're not'). I was like.....,and I told him "Well I felt like you were just putting all of this on my weight and that you are shaming me" and he's like "Well you shouldn't feel that way, you should just lose the weight because that's when things happen". So I went 'Thank you for your time' (Mary).

Mary was once again offered a diagnosis of being ‘fat’ and was told to lose weight was the only treatment. Mary's health could be jeopardized if fear of further shame keeps her from accessing health care. Mary, however, says it won’t, and that she will spend some time to look for a more helpful gynecologist.

**Evolving understanding of health.** Mary spent a significant amount of time exploring her own evolving understanding of health, which she feels, is changing in a good way. She described a shift to a more holistic view of health and exploring alternative medicine. This shift reflects a move away from her 'old views' about health which she described as 'society's views'. She stated:
My understanding of health has more to do with holistic health now….emotional health, and understanding how things like stress and fatigue and working too hard and not having balance affect health a lot, more than people kind of acknowledge. So, just my understanding of how to be healthy and what healthy means is...is different than it used to be (Mary).

There is also a political element to her evolving view of health. Mary said that by talking more openly about her health (and challenging the current assumptions about weight and health) she is challenging the status quo. This challenge to the system has been, she said a result of an increased awareness of negative assumptions and stereotypes associated with larger bodies. In her narrative, Mary considers the power, knowledge and the fallibility of doctors. She believes that the recognition of this fallibility means we need to question more what we are told by doctors, and also learn to pay attention to our own knowledge. Critical thinking, she says, is important because negative experiences with health care professionals increase the likelihood of people ignoring health issues and not accessing healthcare. Mary sees this pattern in herself and her family.

**Key Refrains.** Mary’s narrative has a focus on her evolving understanding of health and her determined quest to find healthcare providers who she can trust to provide the care that she needs. The refrains that appear most often are; shame, default obesity diagnoses, being dismissed or not taken seriously, feminist analysis, the journey, positive or helpful interactions, and insider view.

Mary talked often of feelings of being disregarded/dismissed by healthcare providers. This is tied to how much time the provider spent with her, and how willing they were to explore possibilities/options beyond body size as a diagnoses. Mary also
talked about how important it was to her that doctors take the time to explain any exam or procedures she might be undergoing.

The *shame* Mary experienced accessing healthcare impacted how she related to her own health and wellbeing. For many years she found herself distancing herself from her health concerns. For example, Mary’s first visit to the doctor at sixteen and being told her period irregularity was due to her fatness was traumatic. Her health became something she didn’t deal with because she didn’t know how. She said she ’pushed it into a corner.’ The relationship between body shame and health transfers over to feelings about having conditions that popular wisdom associate with a larger body size. For example, Mary does not generally let people know she has high blood pressure because she feels people will immediately assume it is because of her size, caused by unhealthy lifestyle habits.

Many elements of Mary’s narrative invite a *feminist* exploration of her experiences. For instance, Mary's experience as a camp counselor appears to have been quite influential in shaping her ideas about what it means to be in a position of power and how that shapes our interactions in health care settings. She looked for and found a doctor who demonstrated the kind of power sharing that she learned about at this camp. Finally, through her stories we learn that there are additional levels of power and control that come into play when accessing specialists that can be hard for larger-sized women to navigate.

Mary's experience with being *diagnosed with 'obesity'* defined her earliest experience with health care providers when she sought medical advice for the irregular periods she was experiencing at age sixteen and was told if she lost weight her periods
would become normal. This same obesity diagnoses followed Mary for ten years, until she found a doctor who was willing to consider factors other than her body weight and run some tests. Only then did Mary learn she had cysts on her ovaries and was diagnosed with PCOS. Mary said her current doctor believes there is an association between weight and health but the difference is obesity is not the default diagnoses. Mary told me this has allowed her to no longer ignore her health concerns and take better care of herself.

Mary's quest or journey of accessing healthcare as woman in a fat body underscores her story on many levels. Mary showed an awareness of the complexity of a layered journey when she shared that the work she has done intellectually about weight and health haven't been fully realized on an emotional level. Mary's view of weight and health have changed due to exposure she has had to body positive sources online, information she accessed at a social work conference, and various other sources. The knowledge she has gained has shaped her view of the role of healthcare providers, and her rights as a patient. This state of self awareness is further exemplified by Mary noting that her view on weight and health are currently in flux, that she is open to new information and that there is still more road to travel on the journey.

Mary's ability to challenge health care providers also emerges as an indicator of where she is on her journey. She gives an example of how she stopped seeing one doctor who did not provide her the care she needed. Mary told me she aspires to one day have the ability to let a healthcare provider know when she is finding their behaviours are oppressive. She also referred to her interaction with the gynecologist where, although she was able to express her belief that she was being shamed by his default obesity
diagnoses, she felt it wasn’t effective because she was coming from a place of sadness and tears.

**Ellen**

**Ellen's background narrative.** Ellen, a thirty-two year old woman living in a rural community in Saskatchewan describes herself as a person blessed with good health. She has lived in Saskatchewan for fourteen years and is now married with two children. Ellen shared that she has an active and busy life raising children, running a home based business, engaging with a large circle of friends, participating in sports, and being actively involved with her church community. She said she has never experienced any major health concerns, and only since being married and having children did she engage much with the healthcare system.

Ellen acknowledged life long body image issues, but at this point she is feeling very positive about her body, health and wellbeing. When she was a child, Ellen's mother would make upsetting comments about her body, and her father has made body-shaming comments to her in more recent years, which she ‘defends herself fiercely’ from. Ellen talks of work with a counselor, which has addressed some of the issues from her childhood and contributed to her current positive outlook on her body, life and health.

Participating in this study was of interest to Ellen because of her experiences with the healthcare system in pursuit of breast reduction surgery. Her breasts cause her pain and inhibit her ability to be as active as she would like to be, and that having this surgery would, in her opinion, improve her quality of life. However, Ellen has not found it easy to get this surgery due to her body size (See *Quest for Breast Reduction*).
Ellen describes herself as having a traditional view of medicine and does not see herself as a person interested in holistic or alternative therapies. Rather she expresses a deep respect of the medical profession and the work of healthcare providers, which has contributed to her confusion and upset she is experiencing in accessing a breast reduction. Another important element of Ellen’s story is her belief that a positive outlook on life is a major contributor to good health (see Actual Best Health).

**Ellen's healthcare stories.**

**Quest for a breast reduction.** The story Ellen came to tell, her motivation for participating in this research, is the story of her journey for a breast reduction, and the frustration she is feeling with the healthcare system. This story takes place in the space of more than ten years and in a few doctors’ offices, the first being a General Practitioner (GP) that Ellen used to see, as well as her current GP and finally at the office of a specialist/surgeon. Ellen told me that the first conversation she had with her doctor about a possible breast reduction was in the early 2000’s. She says this interaction left her feeling embarrassed because without examining her (she says she didn’t even take off her winter coat) her doctor quickly dismissed the idea, saying she ‘didn’t weigh enough’.

About ten years later, after her second child was born, Ellen had a new doctor, so once again decided to broach the possibility of a breast reduction. She had a much different reception to the idea from this doctor, who was supportive and more than happy to provide a referral to a specialist. Ellen let her surprise be known to her doctor, and shared with her what had transpired when she first looked for support in getting the surgery. Her doctor told her that as she didn’t have the lived experience of life in Ellen’s body, she couldn’t imagine not supporting her in what she wanted or needed to do to feel
comfortable. She did let Ellen know that her weight may be an issue for the surgeon, and that she was happy to work with Ellen on her weight, if that is what she wanted. Ellen’s rising hopes were dashed when she met with the surgeon who was very clear that Ellen’s weight made her ineligible for breast reduction surgery, citing complications ranging from stitches not healing, to Ellen dying on the operating table. The specialist suggested that if Ellen lost one hundred pounds, she could be considered as a candidate for the operation.

Ellen's frustration around this was twofold. First she considered herself a very healthy person, and did not see how, if it was safe for her to have two C-sections, and if fat people in general are urged to undergo bariatric surgery, why a breast reduction would be unadvisable for her unless she lost one hundred pounds. She found it especially frustrating since she saw a breast reduction as a way to reduce pain, improve her mobility, activity level, and overall quality of life. The other element of Ellen's frustration is that she felt her motivations for wishing to undergo breast reduction surgery were questioned by healthcare professionals and were assumed to be appearance driven rather than for mobility, comfort and health.

It was important to Ellen that I understood that she did not care about changing the way she looked. For instance, Ellen cited the ability to participate more fully in yoga as an example of why she wanted the surgery. Ellen said she made every effort to emphasize her motivations for the surgeon, that she just wanted to reduce the size of her breasts to reduce pain and discomfort as well as improve her mobility. She said she did not feel heard.
Ellen reflected on feelings of shame that she experienced during this consultation. She said “Shame shouldn't be the inherent emotion when you are talking about your health…and yet it is.” She attributed the shame she feels to societal ideal standards of beauty and health. Ellen indicated that she was gearing up to see if her doctor could refer her to another specialist, who she hopes would be more open to ‘being creative’ with Ellen’s situation. Ellen also hoped she can be ‘braver’ in challenging any barriers another specialist might bring up in disqualifying her because of her body size.

Discussion. Looking at Ellen's story through a feminist theory lens, I was struck by how the interactions Ellen describes are shaped by constructs of power and privilege that each of the healthcare providers ascribe to their role. There is a notable contrast between the interaction Ellen has with her current GP and the ones she has with both the specialist/surgeon and the earlier GP. Ellen’s current GP practices a more patient-centered model of care that prioritizes patient's needs and acknowledges the patient’s insight and wisdom. Ellen’s first consultation with a GP is characterized by a brevity that left Ellen feeling dismissed and confused. Ellen mentioned many times that her winter coat remained on during the consultation and contributed to the impression that she didn’t have her GP’s full attention and willingness to explore her needs, let alone conduct an examination or make any kind of assessment about her weight.

Many things contribute to Ellen’s feelings of frustration and confusion. First, the varying responses of the healthcare providers to her desire to get a breast reduction, and ultimately the inability of the system to provide her the care she needs. Another frustration is her inability to understand how, when she lives a healthy lifestyle and
experiences good health, she can be seen as too much of a health risk to access what she sees as a simple surgery that will impact her quality of life in a positive way

**Actual best health.** This story isn't about a particular incident in Ellen’s life, rather it is a story about how Ellen views health. Like Mary, Ellen clearly has an evolving understanding of what health is. I was struck by a phrase Ellen used when talking about the importance of a supportive community in having a healthy life. She said: “I think surrounding yourself with a group that just has happiness and your actual best health in mind for you, is huge.” When I asked her to elaborate on what she meant by ‘actual best health’, Ellen offered an example of the diet talk and body bashing that often goes on in her church community:

There are so many people that are making the comments and not just chilling out about weight and putting themselves into these nice little containers of food. And that's not to say that I will never do that again, but, like, we really compartmentalized about our relationship to food sometimes (Ellen).

Connected to Ellen's notion of actual best health is the frustration she feels when healthcare providers or family and friends assume she experiences ill-health because of her body size. She further to explained that she believes community and positive relationships are more important for good health than trying to conform your body to a certain size. Ellen resonates with the idea that our mental state impacts our physiology and then, by extension, our health. Her experience has been that when she goes on restrictive diets in an attempt to lose weight, she does not feel well. She prefers to stay away from restrictive diets and focus on keeping active.
Ellen’s story is shaped by this understanding of health. *Actual best health*, as she called it, reflects deeply held values and is based on experiences of what has worked for her in her own life. When talking about her health, Ellen was quick to describe herself as someone with a ‘positive attitude’, which she believes is the major contributor to the good health she has experienced. She said that it is all about perspective.

Ellen talked about a shift she had in the last few years in which she finds herself feeling good about her body and her health and wellbeing. When asked what contributed to this shift, Ellen said it was an increasing awareness and maturity as well as some counseling to help her address some childhood issues. She also talked about the realization that she values joy and connection over obsessing over the need to try and look a certain way. Thus for Ellen, actual best health is a view of health that acknowledges her circle of friends and her community as a vital component as well as her own approach to life that combines a practical positive attitude approach to dealing with issues, directly both physical and emotional.

**Key refrains.** Ellen’s story is about a struggle to understand the discrepancy between her positive views of healthcare professionals and the healthcare system with the puzzling and unhelpful interactions she had with healthcare providers in not being able to access a breast reduction surgery. Ellen’s concern is centered on not being seen as healthy by healthcare practitioners because of her size, and as a result facing barriers in accessing the health services she needs. Ellen’s refrains include; *positive or helpful interactions, assumptions, perceptions of health, feminist analysis, the journey, needed health care not provided or accessed, different doctor or specialist.*
Ellen’s said she has been blessed with good health thus far in life and her stories contain many examples of positive or helpful interactions with the healthcare system in Saskatchewan. She felt in general she and her family have received excellent care, especially in terms of her children. Ellen talks of having gathered a net of medical practitioners around her and her family, which include dentists and other health care providers. She said the relationship with her current GP is very positive and she has many stories/anecdotes of situations where her GP was affirming, open to suggestions and supportive of what Ellen wanted for her health and wellbeing.

The desire to have breast reduction surgery has been Ellen's major frustration with the healthcare system. Although her current GP was supportive, she hit another block with the specialist who says Ellen is too fat for the surgery. Ellen believes this assessment was based on assumptions about her because of her body size. First of all, she was assumed not to be healthy, which she feels couldn’t be further from the truth because she takes good care of herself, is active and says she feels 'in the best health of her life’. In addition to assumptions about her health, Ellen feels that assumptions were made about her motivation for surgery, that she wished to reduce the size of her breasts for cosmetic reasons. Finally, Ellen believes that assumptions were made about her activity level in that, because she is a larger person, she is not fit or does not engage regularly in physical activity.

Ellen see's herself as a very healthy person, and says she has never had to deal with a major health issue and that she was rarely sick. She attributed her good health to a positive attitude and for her, indicators of health included happiness and being a close-knit family that supports one another. Ellen greatly values connection not only with her
family, but also with her friends and her church community. She believes that the focus of trying to achieve the ideal thin body can be a detriment to personal connection, especially social connections that can happen over a good meal. She says she decided to value personal connection more, what she refers to as ‘actual best health’ and this is what has contributed to her feeling good about herself.
Thematic Analysis

Introduction

To weave the stories of these three women together and attempt to come to a common understanding of their experiences, I engaged in a process of reviewing, sorting and grouping together refrains (or nodes) in the data that had significant commonalities or relationships, and spoke to answering the research question: "What are the experiences of fat women in Saskatchewan accessing healthcare?" Out of this process six broad themes emerged that together create the tapestry reflecting common experiences of these three women. First, I present the particular 1) Health Challenges experienced by the participants. Then I discuss both 2) Implicit and 3) Explicit Weight Bias underpinning many of their interactions with healthcare professionals that include assumptions that are made about the participant’s lifestyle habits, along with the relentless default obesity diagnoses that permeates each woman’s story. This is followed by an exploration of the 4) Negative Impacts of healthcare interactions for these women, and the 5) Ameliorating Conditions, or the way these women have worked to take care of themselves in often stressful situations. Finally, the theme of 6) Advocacy maps the increasing recognition the three women have of the oppressive nature of the way healthcare has been provided to them. The Advocacy theme is also a chronicle of how the participants are moving away from self-blame and recrimination that has characterized how they felt about their health toward a place where they can be self-advocates in their interactions with the healthcare system.

Finally, as I reviewed the data and considered each woman's story, a larger story emerged, one that encompassed the experiences of all three participants. This story, what
I have come to call *The Journey*, is the story of Jane, Ellen and Mary's increasing recognition of the injustice of their experiences accessing healthcare and how they coped with it.

1) Health Challenges

“And so you're not going to get healthier, if ...if you're always...like in a bad mental space. And when you're...when you feel like your battling your body instead of living in your body. And so...shame...makes your health worse.” (Mary)

Any reflection on interactions with the healthcare system is going to happen within a context of the particular health challenges of the individual, ranging from chronic conditions to accidental trauma. Sharing the stories of these challenges provides a context to better understand the experiences of the participants accessing healthcare while living in larger bodies. The refrains in the data that emerged together under this theme included *Family Health Patterns, Fertility Issues* and *Long Term Impacts*.

Long term impacts. Of these three, *Long Term Impacts* are explored more closely as it seems especially significant to consider health challenges that the participants believe resulted from lack of, or inappropriate care received because of their body size. Ellen experienced long term impacts on her health when denied breast surgery because of her size, as her mobility and quality of life are lessened. Another example is Jane, who continues to have issues with her ankle she attributes to both the refusal of an ER doctor to treat as a serious injury, as well as the orthopedic surgeon who, although acknowledging the seriousness of the injury and the need for surgery, refused Jane treatment because of her size. Jane says her ankle often gives out on her, reducing her mobility and opportunity to be active and putting her a high risk to re-injure herself.
My life, right then and there, because even though I was being active, right up to that point, even though my body had been starting to change, me becoming blubbery and fat. I was still always active, I always was out doing things, doing things with the dogs. We would walk at least two miles a day with those dogs, every day! All of a sudden I had an ankle I couldn't walk on (Jane).

Another example is Mary's PCOS, which went undiagnosed for many years because her irregular periods were attributed to her body size.

PCOS is probably the thing that I have the most emotions attached to because.. since I ...pretty much since I got my period and for sure since I was around 15 or 16 I had very irregular periods, and very infrequent and, um, was misdiagnosed a lot. With just being overweight (Mary).

2) Implicit Weight Bias

First thing they say, 'well you gotta get out and move'. I'm like, "I'm not a couch potato. I'm not the kind of person who sits on the couch and doesn't do anything"

But I'm getting to the point where I can't do anything, because anytime I do anything I fall, or I hurt myself (Jane).

Implicit bias is the expression of negative assumptions or stereotypes about a particular group that are present in interactions, but often not readily evident or consciously recognized by the victim or the perpetrator. According to Phelan et al., (2015), these unconscious automatic behaviours enacted by healthcare providers toward fat or larger-bodied people are often the result of deeply seated beliefs about a group of people and can affect the experience of accessing health care and, on an unconscious level impact the post-visit decisions of the patient. In reviewing the data, it became
apparent participants experienced implicit weight bias in a variety of ways, including *Feeling Dismissed* (or not having their concerns being taken seriously), *Assumptions*, (having assumptions being made about their lifestyle habits), and *Default Obesity Diagnoses*.

**Feeling dismissed.** Mary's relief to have found a doctor who isn't dismissive is palpable, she says:

She's still, like...associates weight and health, almost like any doctor, probably. Um, but doesn't stop there. She goes to other stuff, and looks at the big picture as well. She's at least willing to….do some looking. So, yeah - that's been good because I feel like I’m not just being ........disregarded anymore (Mary).

Mary says prior to finding her current doctor, the feeling of being dismissed or not taken seriously by doctors was a serious ongoing issue for her. She talks about the first time she went to a doctor about the problems she was having with her periods. She says the doctor didn't examine her, nor take any kind of medical history, and was quick to attribute her problems to her body size and prescribe weight loss. Jane felt dismissed when she seriously injured her ankle, which she attributes to not being someone who 'looked athletic'. She also felt dismissed the time her new diabetes medication caused her blood sugars to spike and crash, symptoms she felt she couldn’t get her doctor to acknowledge, let alone address. Ellen had a similar experience when she first approached her GP about a breast reduction, who quickly dismissed the idea without examining Ellen. All three participants experience interactions with healthcare professionals that seemed rushed and did not include physical examination or tests.

**Assumptions.**
So I probably didn't...present as somebody that was very...like I never had any
beautiful hair...I still don't do the hair, the makeup, the nails...the...you know? So I
...you know, I'm tired, I'm not feeling well...I'm probably in baggy mom clothes I
didn't have much of anything else beside baggy mom clothes. I'm fat.... and that's
the assumption (Jane).

"The specialist would have looked at me and thought 'You must be an immobile
person' or, you know? I felt like he assumed I led a certain life…” (Ellen)

Implicit weight bias is the result of assumptions people have about fat people, and
all the participants expressed frustration at the assumptions healthcare professionals
routinely made about them. Ellen resented healthcare providers assuming she is
unhealthy because of her because she has a view of herself as a person who is
conscientious about her health. Jane talks a lot about assumptions she feels are made
about her including that she is inactive, non-compliant, and that she isn't working to
improve her health and wellbeing. This was made clear to Jane in a consultation with her
child’s pediatrician where the doctor suggested that she restrict the amount of soda and
potato chips her child eats, despite Jane's assertions that due to their financial situation
junk food is a treat, rather than an everyday occurrence, at her house.

**Default obesity diagnoses.**

Every time you go to the doctor and you have, like I can't even remember what it
was, and I said 'well one of these day I'm going to walk in there with a sore finger
and they are going to tell me I'm going to have to lose weight because I have.. to
fix the sore finger.’ Because it didn't' matter what I went in to see the doctor for,
whether it was the flu, or my diabetes, everything...every single time it was 'well, you're too fat, you need to exercise, and everything is your fault' (Jane).

All three women have been impacted by repeated occurrence of the phenomena identified in the literature as a Default Obesity Diagnoses, which is the experience of having a healthcare workers regularly ascribe blame for a variety of illnesses or conditions to a patient's fatness. Mary experienced a default obesity diagnoses at her first significant interaction with a healthcare provider was when she was sixteen. She left that interaction with no answers for her irregular periods other than her fatness was to blame and 'losing weight was her job now'. She was not examined and no tests were done. Jane told many stories of how she and other people in her life receive default obesity diagnoses. Her stories highlight the seriousness of the issue and suggest healthcare provider’s focus on obesity detracts from finding and treating what is actually wrong with the patient. For instance Jane says about a friend of hers: "And after a few months when she just wasn’t' getting any help and she's like 'pretend I'm a hundred pounds...and tell me what's wrong with me'. And he's just like....it made him look for it and....she had cancer." (Jane).

3) Explicit Weight Bias

"It's like it wasn't, I wasn't...important enough. Or, um significant enough of a person, that it was something that it should be his problem to have to deal with it at the time." (Jane)

Explicit Weight Bias is demonstrated by attitudes and actions that are conscious and reflect a person's opinions and beliefs about fat people (Phelan et al., 2015). These are the experiences of the participants where negative feelings about fat people held by
healthcare workers or other people in their lives were clearly demonstrated by comments or actions. Examples of explicit bias experienced by the participants are found in data in the refrains of *Weight Bullying, Shaming / Unkind Treatment, and Fear of Healthcare Professionals*.

**Shaming or unkind treatment.** All three participants told stories of being bullied because of their body size at some point in their life. These are interactions that are typified by verbal abuse, being called derogatory names or receiving negative commentary about body size or weight. For the most part, explicit bias experienced as bullying did not happen in the healthcare area. Participants were more likely to experience in schoolyards, at the workplace or within a family dynamic. However, *Shaming or Unkind Treatment* was a common experience for all participants in healthcare interactions. These included interactions in which participants perceived a negative attitude or were not treated kindly and subjected to comments such as 'you're too fat to fit in the MRI machine', or 'when you're bigger, you fall harder', often these comments left the participant feeling they were to blame for their illness, condition or injury and further implied they were a drain on healthcare resources. This is especially evident in Jane's story of being in the ER late at night due to a negative reaction to a new diabetes medication, where she recalls the attending doctor saying to her "you're fat and out of shape and ah...you should be taking better care of your diabetes, and.. you have little kids at home that you should be caring for and not be doing this."

**Fear of healthcare professionals.** All the participants expressed some form of *Fear of Interactions with Healthcare Professionals*. These were experiences such as doctors' comments about weight/body size triggering upsetting memories of weight
bullying, visits to healthcare professionals inducing White Coat Syndrome (spikes in stress indicators like high blood pressure), and participants choosing to not access healthcare at all because of fear and/or shame.

“It's sad that we have to like find these magical doctors that aren't horrible, oppressive people, shaming us to...maybe go. Like, this should be the standard, that doctors aren't oppressing their patients but!...it's not.” (Mary)

4) Negative Impacts

Because, if you have enough negative experiences, it is very easy to just ignore health issues. Because you don't want to have more negative experiences. And so, like that is what happened to me and, but it also is a cycle in my family (Mary).

Through the stories of Ellen, Mary and Jane a range of negative impacts or challenging experiences arise out of their interaction with the healthcare system. These negative impacts are seen in the data through the identified refrains of Shame (internalized stigma), Self Blame, Stress, Depression, Not Accessing Healthcare, and Entrenchment in the Diet Culture (intentional weight loss, Good Fatty Syndrome). It is evident that interactions with the healthcare system can have negative impacts on the participant's mental health as represented by many of these nodes or refrains. I offer a more in-depth look at the refrain of Not Accessing Health Care.

Not accessing health care. “I had a lot of shame around that, and it was something I didn't talk about, it was...pushed into the corner. And so...my health was also just not talked about, not thought about, pushed into the corner as well." (Mary)

Perhaps one of the most disturbing recurring refrains in the participant’s narratives are the stories shared about instances when the shaming experienced accessing
healthcare results in people in larger bodies simply not accessing health care at all. The strategy of simply not going to the doctor was reflected not only in the stories the participants shared of their own experiences, but also in stories of other people in their lives. For instance, Mary tells of her aunt who has not gone to the doctor for many years because she fears being shamed about her size. Because of the positive experience Mary is having with her current GP, she is hopeful that she can convince her aunt, and other friends and family members who avoid doctors of our fear and shame to re-engage with the healthcare system.

..you know that you're gonna get the lecture. You know you're gonna get this....be demeaned and told how you're such a ...fat person and then my blood pressure...every time I was there, my blood pressure would be so high! So then they were saying well I have high blood pressure, and I'm like "I don't have high blood pressure, it's just coming here that gives me high blood pressure"....like you know (Jane)?

5) Ameliorating Conditions

Once I started going to that First Step Program, it's such a safe environment. Because you are there with people who are just like you. Like, it's not a bunch of athletes that you are working out with. You're working out with other people that have diabetes, other people that have health issues, other people that don't move very well and they have their own room, so you're not in where all these muscular people are, and it's a very safe environment (Jane).

The refrains of Positive Attitude, Positive or Helpful Healthcare Interactions, Self Care were identified in the stories of these three women as experiences and strategies
employed by the participants that provided a place of safety amidst the stress and pain of their experiences accessing healthcare.

**Positive attitude and self care.** Ellen in particular talked of the importance of a *positive attitude* in living a healthy life. She tells stories that not only show how a positive attitude contributed to her good health, but also how she feels it is important to have a positive attitude about healthcare providers, and indeed the healthcare system, which she is appreciative of. All three women had stories of positive interactions with healthcare workers that they were deeply grateful for.

*Self-care* plays a big role in countering the negative impacts of the weight stigma faced accessing healthcare, not only emotionally, but physically as well.

Like...at the end of the day...you know...did you sit down and have a piece of pizza with your kid, or your friend and laugh and have like a greater sense of happiness over that...like that to me, is more.. worthwhile, health-wise than 'oh, today I ate five, like wasa thins with tuna on them and worked out for two hours.' I mean, I guess I would say like health to me...actual health?....is tied to mental health and mental happiness  (Ellen).

“My current one (doctor) has made me more open to healthcare….Once you find a good one, you cling to them”. (Mary)

6) **Advocacy**

"Look at me like I'm a skinny person, and then tell me what might be possibly wrong with me. And we'll work from there." (Jane)
And I decided to ...um...just like be more aware of what was going on, and it was kind of when I started to decide to go into social work and, you just become more aware.......of yourself, because you learn to become more aware of others. (Mary).

This theme is about the participant's increasing understanding that the personal is political when it comes to their body size and the healthcare they receive. It is descriptive not only of the inner shifts of all three participants, but also of the changes in perceptions and understanding as they have come to recognize the impact of weight bias on the healthcare they receive. These are the incidents and realizations that have supported the participants in developing a critical understanding of their experiences. Refrains in the data that have come together in this theme include; *Issues of Gender and Power, Understanding of Health, Challenging Healthcare Providers, Family Body Type, Personal Growth, The Stories of Others, and Specialists.*

**Understanding of health.** All three participants told stories that reflect an increasing understanding of health, independent of body size, or weight. Mary especially talks about how she is shifting away from the traditional view of weight and health to a more holistic approach that focuses less on weight and more on other factors, especially addressing issues like stress. "My understanding of how to be healthy and what healthy means is...is different than it used to be. It's not just doctors, or taking medicine. It's a lot more than that." Ellen used a term 'actual best health' that caught my attention, and when I asked her what she meant by the term, she explained that, in her view, relationships and positive community connections are a better reflection of health than dieting down to a particular body size or weight.
I catch negative assumptions a lot more than I used to whereas I just sort of accepted things before, I see them now and I'm aware of them, and I’m aware of just like accepted negative stereotypes a lot more than I used to be? But I'm also more mindful of arguments against those and ways to kind of.. challenge them? Which I'm thankful for.. (Mary).

**Challenging healthcare providers.** All three participants talked about challenging healthcare providers, both the experiences they have had to this point, and the desire they have to be better able to challenge things like *assumptions* or *default obesity diagnoses*. Jane spoke with admiration of a friend who challenged her doctor by saying "look at me like I’m a skinny person and tell me what might possibly be wrong with me". She mused what it might take for her to be able to address a healthcare provider so directly. Ellen also pondered the same question, if she could become 'brave enough' to challenges assumptions healthcare providers have made about her because of her weight. Mary talked about how her awareness of negative assumptions is increasing and that she is working at becoming more vocal with her healthcare providers. She says:

*That doesn't mean that they're terrible people, but it means as a general public we need to question more...and listen to our own selves more and if we think that something is wrong and they say 'no' or if they say it's this, when you don't think it's that maybe you look into it a bit more (Mary).*

**The Journey - The Window Becomes the Mirror**

The participant's *Journey* story includes each of their struggles with feelings of ambivalence about their body size and how it relates to their health and wellbeing. *The Journey* is the story of how each woman is becoming an advocate for herself, an
expression of their desire to challenge the relentless default obesity diagnoses of healthcare providers in order to have better access the healthcare they need and deserve.

Examining The Journey through a feminist theoretical framework, it is evident the participant's Journey is a process of each woman understanding that she needs to look to the wider community and the prevalence of weight stigma to understand her personal experience of unhelpful and even hurtful healthcare interactions. It is a journey of the personal becoming political.

The Journey is evocatively described by Jane, who begins to make comparisons between how she is treated by healthcare providers, and how her First Responder colleagues would make judgments about fat people in their care. She says:

So, those kinds of things that you just observe, and that you are just kind of watching through a window. Then when you move forward into your own life and you're not doing that job anymore…and all of a sudden you become the patient… all of a sudden you are seeing that reflection back…as to how you were treated. And you're the fat patient (Jane).

The window, for Jane, became a mirror. The transition from looking through the window to looking into the mirror was a process of recognizing their personal experiences as something larger than themselves.

Each woman has their own unique experience of this journey, of seeing the oppression they face as ‘the fat patient’, but what is key to this larger story is the awareness each woman has, a consciousness of the journey, that keeps each of these women engaged with the healthcare system despite the oppression they face. Actions like practicing self-care or finding healthcare providers that will look beyond a default
obesity diagnoses. Their awareness of The Journey keeps them from fully internalizing the weight stigma they have encountered, offering the possibility that they are not intrinsically unhealthy and that perhaps the constant focus on their body size during interactions with healthcare providers is unwarranted and unhelpful. I believe it is this awareness that attracted these three women to participate in this study, and may differentiate them from other fat women who have more fully internalized the weight stigma they have faced and feel shame for living in larger bodies, blaming themselves for any health issues they may be facing. These participants are representative of women who have begun to recognize the unfair assumptions they faced accessing healthcare, and are looking to share their stories and hopefully contribute to improving the situation for all larger-bodied women.

Unfortunately this means there are many women who have not seen themselves reflected back in the mirror or recognized they are being treated unfairly because of their size. They may accept, without question, the shaming behaviours of healthcare professionals and make (often futile) attempts to lose weight. Or, they find the shaming too hard to face, and like the women in Mary's family, opt to stay away from doctors and deny themselves healthcare.

Jane. There are many moments in Jane’s narrative that speak to her increasing awareness of the oppressiveness of her experiences accessing healthcare because of her body size. Her frustration at the constant default obesity diagnoses is evident when she jokes about going to a doctor with a sore finger and expecting to be told to lose weight. Another integral part of Jane's journey is the insight that her experience as a First Responder has given her. Because she witnessed other fat people being stigmatized by
her First Responder co-workers, she was able to identify the oppression she herself was facing in healthcare situations, and the assumptions that were made about her.

Jane's awareness of *The Journey* was accelerated by the reaction of healthcare providers when she registered for the bariatric surgery program. The immediate and overwhelming surge of positive feedback from healthcare providers did not sit well with Jane who was ambivalent about undergoing the weight loss surgery in the first place. She says she did not appreciate how all the work she has done over the years in staying active and taking care of herself never seemed to be acknowledged by healthcare providers, but enrolling in the bariatric surgery program immediately garnered her praise and positive reinforcement. She began to see more clearly that healthy behaviours were only acknowledged and applauded if they resulted in a smaller body size. And since the surgery was seen as a ‘magic bullet’ to a smaller body size, it was immediate deemed praise worthy.

At the time of our interview it had been almost a year since she had the surgery and Jane tells me she has not lost weight, which is baffling her doctors. However, she notes that she has shifted down in clothing size, which continues to encourage a shift in her thinking. Jane feels the injustice that her shift in size/body composition is overshadowed by the lack of change in weight in the eyes of her healthcare providers. Jane tells me that she is nervous about the one year post surgery follow ups she is about to embark on because she is certain all the good that she has done for herself will not be acknowledged and the focus in her healthcare interactions will be on the weight which has not been lost. She appears to be realizing more and more how unhelpful and unfair this weight-centric approach to health is.
Mary. Mary's awareness of *The Journey* is acute and throughout her narrative she seems to be exploring and processing her understanding of it on many levels. This awareness is in the foreground of her consciousness partly because embarking on *The Journey* is a relatively recent development for her. Mary says attending an educational event about weight stigma a few months ago significantly increased her awareness of how she looks at weight and health. In the wake of the awareness gleaned from the event, Mary has been actively educating herself on issues of weight and health by reading books and following body positive and HAES® advocates online, contributing to her awareness of weight stigma and the impact it has on her accesses to medical care. Mary’s story also demonstrates an intellectual understanding isn’t all that is needed in a journey like this one. There is often a disconnect between an intellectual understanding and the emotional reality of the relationship between body and health. Mary says her emotional understanding is not at the same place as her intellectual understanding of weight and health and she still feels emotionally vulnerable.

Mary’s quest to find a doctor that works for her has been the central focus of her journey to this point. In our conversation, Mary was quite clear that she needs a doctor who provides options for her healthcare and takes the time to explain what is happening during physical exams and other interventions. Significantly, she is looking for a doctor who doesn’t consistently default to a diagnosis of obesity. As someone who works within the healthcare system, Mary is also aware of the systemic issues and stigma faced by fat people accessing medical care, including the use of stigmatizing terms such as ‘morbid obesity’ that attempt to medicalize fatness through language.
Finally, another significant element in this journey for Mary is her day-to-day life and how she cares for herself. She says her health and wellbeing have improved as a result of her change of perception around weight and health. She is able to engage in physical activity and other healthful behaviours more consistently because she is less tempted to take on 'extreme' self care plans like a rigid diet plan such as Paleo, or going to the gym everyday to achieve weight loss.

Ellen. Ellen's journey is one of recognizing and valuing her view of health where things like a loving family, a tight-knit community and an enjoyable relationship with food play an important role. In our conversation, Ellen made it clear that she is someone who generally has a huge respect for the medical profession and appreciation for the Saskatchewan healthcare system. Ellen’s Journey is guided by a strong belief that a positive attitude has a significant influence on health and wellbeing. She is confident in her view of herself as a healthy person living and healthy life, which causes a jarring dissonance for her when healthcare providers tell her that her body size makes her inherently unhealthy. This dissonance is a strong indicator of where Ellen is on her Journey. She knows she is healthy and when she is told otherwise by doctors, she just doesn't buy it.

"I just feel a sense of comfort, and health, and just wellness that I never had before, even mentally and I think it just channels itself physically." (Ellen)

Ellen's quest for breast reduction has thrown the negative bias toward heavier bodies in health-care into sharp relief, and she is beginning to question the infallibility of doctors. Ellen is also questioning the recurring experience of feeling shame in encounters
with healthcare professionals. She says "I don't know, like shame shouldn't be the inherent emotion when you are talking about your health. Right?"

To more fully understand The Journey and each of the participant's experience of it, it is important to recognize we are living in a time of emerging body positivity messaging. Alternative approaches to weight and health like Health at Every Size® that contribute to sparking the recognition of The Journey in many women and play a role in countering the weight bias found in the traditional approach to weight and health embraced by most healthcare professionals. However these emerging ideas are still but a drop in an ocean of prevailing acceptance of an ideal that puts a thin body as reflective good health. Mary acknowledges this when she talks about the conscious effort she has made to bring body-positive content to her experience of social media. Although she says ensuring her consumption of social media is generally body-positive has had a favourable effect on how she experiences her body, it does not mean the world has changed. Mary still must face weight stigma in her day-to-day life, and when she accesses healthcare.

Summary

This chapter introduced the three study participants Jane, Mary and Ellen and their stories about their experiences accessing health care in Saskatchewan as larger-sized women. I shared my process for exploring and understanding the emerging refrains in each participant’s story and shared the common themes that emerged from looking broadly at the stories of all three women. This included an overarching theme I called The Journey, representing the participant's recognition of the injustice of weight stigma in the healthcare system. Also explored were how the participants are working to resolve their
feelings of ambivalence about their body size and how they are each exploring how they can advocate to challenge the relentless default obesity diagnosis offered them by healthcare providers. The next chapter will explore the findings in relation to the literature. The potential impacts of this research will also be presented.
Chapter 5 - Discussion

Introduction

In this chapter I begin by providing a brief synthesis of the goals and findings of the study, revisiting some of the themes that emerged in the literature review and how they resonated with the experiences of the participants. I will also suggest what new insights this research has to offer into understanding the experiences of larger bodied women accessing healthcare. The key contributions of this study will be explored, including how the study findings are supported by and also add to the current literature on the subject of weight stigma and health. Finally, a discussion on the implications for practice, both in social work and in healthcare generally as well as consideration of possibly policy implications is followed by a final summary.

In this study I have looked to address a particular research question: "What are the experiences of women who identify as ‘fat’ or ‘overweight’ in accessing healthcare in Saskatchewan?". To this end, I engaged with the stories of three women who participated in the research study. Analysis of the data suggests confirmation of two themes that emerged from the literature review. First, much of what was asserted regarding the prevalence of weight bias in healthcare interactions as described by Forhan and Salas (2013) was confirmed by many aspects of the participant's shared experiences of accessing healthcare including having less time with healthcare providers, and provision of fewer interventions. Second, the negative impacts experienced by larger-bodied patients as suggested by Drury and Louis (2012) were also realized by the participants when the stigma they faced accessing healthcare impacted frequency, quality and appropriateness of health care they received.
What is new and revealed by engaging in-depth with these stories is an initial understanding of what it is about these three women, their character, values and experiences that appears to buffer them from fully internalizing the weight stigmatizing messaging so often encountered by people living in larger bodies when accessing healthcare. As a result, they seem less at risk for believing all their health concerns are a result of living in a larger body, which appears to protects them from the self-blame and stress that can come with fully internalizing shame and self blame for living in a larger body.

The participants also seem protected from the often-employed coping mechanism of simply choosing not to access healthcare, which can have serious impact on morbidity and overall wellbeing. This study has highlighted the factors that supported the participants to continue to actively care for their health and well-being and continue to engage with the healthcare system, which is significant for future practice and policy implications. It is the recognition of The Journey as explored in the previous chapter, where the window becomes the mirror and the participants recognize, and take a stand against, the oppression they face as fat women accessing healthcare.

Key Research Contributions

The stories of Jane, Mary and Ellen are reflective of the experiences of many larger-bodied women accessing health care and support the findings in the literature about the negative impacts on their health and well-being. That all three women's experiences of accessing health care were fraught with experiences of implicit and explicit bias unfortunately comes as no surprise. MacInnes (1993) describes weight stigma as being so common it is rendered invisible. This means that often actions and
comments are not recognized as being biased and stigmatizing, by either the healthcare professional or the patient. This invisibility is demonstrated in the implicit weight bias experienced by the participants, in their experiences of feeling dismissed or not having their concerns taken seriously, having assumptions made about their lifestyle habits, and routinely being diagnosed with 'obesity', often without consideration of other possibilities.

All three participants talked at great length about the frustration they felt when healthcare providers would routinely make assumptions about their health and lifestyle habits. The assumptions described by study participants echo the assumptions reported by Puhl and Huener (2009) that include beliefs about the self care habits and lifestyles of fatter people, the presumed negative impacts of living in a larger body and the widely accepted ‘treatment’ of trying to make fatter bodies into thinner ones through intentional weight loss interventions.

Mulherin’s (2013) assertion that weight stigma contributes to stress, and has a negative impact on self-care and healthy lifestyle habits, is evident in the stories of Jane, Mary and Ellen. Many of the negative impacts of weight stigma in healthcare that were described in the literature were reflected in the participants stories when they talked about feelings of shame (internalized stigma), self blame, stress, depression, and even choosing, in some instances to simply not access healthcare.

What emerged in the data that was not evident in the literature about weight stigma and access to healthcare are the experiences that surface within the themes Ameliorating Conditions and Advocacy. These themes offer insight into how the study participants recognized the biases they are facing and the work they are doing to
positively impact their health and wellbeing and to feel safe enough to continue accessing healthcare in this milieu of negative assumptions about larger bodies. This exploration provides a possible contribution into the gap in the literature identified by Burgard (2009) who suggests that there is a lack of research on the factors that support long-term engagement in health behaviours. These stories are ones that show the participants coping with oppressive healthcare interactions through the use of self-care techniques such as cultivating a positive attitude, engaging in personal growth and connecting with others.

These stories of empowerment are especially significant when considering the feminist theoretical lens that underpinned the conception and design of this study. This research has provided an opportunity to reflect on the struggles of each woman in accessing healthcare and how in identifying the oppression she experiences, she continues to reclaim her power in the healthcare provider/patient relationship. Each woman is engaged in advocacy in their own way, through exploring their own understanding of health, challenging the default obesity diagnoses of their healthcare providers, or exercising their power by changing healthcare providers. Relating their own experiences to the current unrealistic thin body ideal and connecting the stories they heard from families and friends with their own provided a foundation for not only recognizing the bias they experience accessing healthcare as oppressive, but also in looking for ways to counter it.

**Implications For Practice**

The design and nature of this study being an in-depth exploration with a small sample size does not lend itself to the findings being generalizable to the larger population. However it does, as Reimsman (2008) suggests, provide an opportunity for
understanding how larger social structures impact the consciousness and identity of individuals, as well as suggest potential areas for further exploration. The stories of women who live in larger bodies and their experiences accessing healthcare in Saskatchewan are a window to how health programs and policies impact women’s health and wellbeing. A deeper understanding of this relationship allows for consideration of some possible positive progressions in addressing the negative impacts of weight bias on women’s health. Specifically, I hope the stories of Jane, Ellen and Mary will encourage reflection on how weight stigma impacts women’s pursuit of health, including how health care services are offered.

Health care professionals. The stories of Jane, Ellen and Mary are rich with insight and information that can inform healthcare provider practice norms when working with larger-bodied patients. Broadly speaking, healthcare providers are encouraged to consider how often ‘obesity’ is offered as a default diagnoses to fatter patients in their practice and to challenge themselves to take a lens beyond weight when it comes to diagnosis and interventions. A weight neutral approach is encouraged, in which generally the testing and examinations that are offered a thinner bodied patients are offered to fatter patients with the same symptoms/health complaints. Clifford (2015) urges healthcare professionals to explore “non-diet interventions to influence variables beyond weight such as eating behaviour, biochemical indices, fitness, anthropometrics, nutrient and energy intake, body image, depression, anxiety and disordered eating” (Clifford, p. 152). Finally, healthcare providers can greatly improve their relationship with fatter patients by avoiding assumptions about lifestyle behaviours. Many larger-bodied people are actively engaged in regular physical activity, are conscientious about
their diet, avoid excess alcohol, etc. Before prescribing any lifestyle changes, it is helpful for healthcare providers to check in with their patients to see what they are already doing in these areas (Ferrante et al., 2016). When healthcare providers make assumptions that larger bodied patients are not active or concerned about nutrition, it can be demotivating for patients who start to feel that unless their efforts result in smaller bodies, being active or eating healthfully is not doing their body, or health, any good. Ideally interventions focus on health as both the primary motivator and desired outcome for behaviour change, rather than messages that emphasize achieving an ideal weight, which may perpetuate stereotypes and shame fatter patients.

**Social workers.** Social workers, especially medical social workers, will find much in the above recommendations for healthcare providers that applies to their work with fatter people. For social work practice in general, it is helpful for practitioners to reflect on the prevalence of body commentary in their discourse with clients and it is a good practice to check assumptions we may have about a client’s diet and exercise habits based on body size. Our work with larger bodied clients (as with any client) ideally has a focus on factors within the client’s control (such as activity level) and it is important to ensure any praise or validation is centered on factors within client control rather than weight (Clifford et al., 2012). Other steps social workers can take include; being careful about negative comments about weight (theirs or others), avoiding fat jokes, being aware of moralizing health supporting behaviours, i.e. comments about being ‘good’ or ‘bad’ in terms of food or exercise.

**Indicators of the Journey ~ Fat as a social work issue.** In the literature reviewed it is suggested that social workers have been reluctant to acknowledge weight stigma as a
social justice issue (Freidman, 2012). Jane, Mary and Ellen’s stories of their health care experiences offers potential insight into ways social workers might develop a deeper understanding of the issue of weight stigma and access to healthcare for larger bodied people. While reading the participant’s stories and analyzing the data, I began to note indicators, or markers of The Journey that seemed to resonate with all three participants. These indicators (as shown in Table 1) emerged from the stories and reflect their level of recognition of the injustice of their experiences accessing healthcare and how they coped with it. I see these indicators as actions, or ways of being that suggest a level of awareness of the oppressive nature of the healthcare system. As social workers, I believe an awareness of these indicators can assist us in informing our own understanding of the oppression fatter people face in accessing health care as well as informing our work with women who live in larger bodies, supporting them in resolving their feelings of ambivalence about their body size and how it relates to their health and wellbeing.

Table 1 offers both the 'negative' and 'positive' aspects of indicators related to weight injustice awareness. They are conceptualized on a continuum that could be helpful to social workers engaging in this work, both in direct practice and in community-wide initiatives to bring awareness to this issue. These indicators could also be used as the basis for an educational tool for social workers and other healthcare providers either as stand alone workshops or possibly integrated into current curriculum.
Social workers have a role to play in the advocacy/social justice aspect of the weight stigma fat people face while accessing health care (Friedman, 2012). By bringing the issue of weight stigma into our social justice discourse, social workers can work to illuminate that which has been rendered invisible, to shine the light on the injustices faced by fat people when accessing healthcare. Social workers also have a role to play in supporting the larger community in untangling our preconceived notions of fat people from our conditioned repulsion of fat bodies and the stereotyped characteristics they have been imbued with. We can use our position and resources to look into the relationship between big business and health policy to ask ‘who benefits?’ from the continued focus on weight as the de facto indicator of health. We can further consider how concepts and language such as 'obesity epidemic' enact a form of coercive control in healthcare interactions, misinforming and disempowering patients. As such, this study may be a
starting place for the examination of needed structural shifts related to power dynamics in healthcare interactions. The findings from this study lend to creating a space for conversation within healthcare education and curriculum on the impacts of weight stigma. Finally, social workers can work to ensure the inclusion of fat people in any effort to raise awareness of these impacts in the healthcare field and in any changes to policies or programs that emerge to address weight stigma.

Policy Implications

This study provides an argument for potential positive change in delivery of health care and social services that is supportive and welcoming to people of all sizes. To support the practice recommendations offered above for healthcare workers and social workers, organizations can consider adopting a weight neutral approach to health, such as Health at Every Size®. The aim would be to generate policies, practices and programs to support a healthcare environment that is not only welcoming to people of all sizes, but ensures we offer interventions that 'do no harm' as evidenced in the current traditional paradigm where we continue to offer treatments that aim to reduce weight at the cost of all other health concerns. A weight-neutral approach to health resonates with the pragmatic and rights-based harm reduction approach to health and well-being. An example of such an initiative would be a broad-based weight stigma-reduction education for healthcare providers. In British Columbia a resource called Balanced View is available to healthcare providers. Balanced View is “an online learning resource designed to raise awareness about weight bias and stigma in health care” (https://balancedviewbc.ca/).
Reconsidering the use of the BMI as a measure for health and/or criteria for treatment or procedures is another potential policy step that would support reducing weight stigma in health care. The recognition that the BMI is an unhelpful, even harmful tool to use for individual health assessment is steadily growing, a criticism that includes researchers and healthcare professionals who subscribe to the traditional approach to weight and health. Finally, on a public health level, public health communication messages can be screened for stigmatizing content. For instance, unhealthy eating behaviours, such as fast food and soda consumption, can be discouraged for all people, not just fat people. This is especially important when it comes to the development of public health messaging for children. The so-called 'child obesity epidemic' has invaded the public consciousness resulting in policies and programs in which the goal is to reduce weight in children. Like adults, children benefit from shifting focus away from weight to, at the very least, elements they have some level of control over such as activity level and eating habits, which reduces risk of feeling body shame and disordered eating behaviours.

**Implications for Future Research**

The intent and design of this study provided an opportunity to bring awareness to the experiences of larger women accessing healthcare. While not the intent, the small study sample does not allow for broadly generalizing the findings to the population at large. However, transferability of the findings related to theoretical understanding does suggest value in further study. For example, the participants in this study represented a homogenous sample of women who all presented as Caucasian and did not self identify as any cultural minority. Future research considering the experiences of women from a variety of cultural and socio-economic backgrounds would provide valuable insight into
the intersectionality of weight stigma and other determinants of health such as race, income and education.

A potential inquiry could include the design of a weight neutral intervention, perhaps a six week psycho-education course that teaches women about the Health at Every Size® framework and includes pre and post test evaluations that measures both psychological and physical indicators of well being such as, for example, self esteem, body satisfaction, and blood pressure. An initiative such as this would provide the opportunity for the participants to make connections, contributing to increased empowerment and opportunities to share their stories.

Summary

This study aimed to address the research question of “What are the experiences of women who identify as ‘fat’ or ‘overweight’ in accessing healthcare in Saskatchewan?” The findings, including the refrains and themes that emerged from the data, are demonstrably evident in their applicability to the research question and are consistent with the current body of knowledge in the area of weight stigma and health. The narrative approach resonated with the material-realist ontology of the researcher providing a space for ‘multiple realities and multiple truths shaped by factors such as race, class, gender, age’ (Mayan, 2009). The ‘truths’ of all three women were embraced and retold through the lens of the researcher. In terms of a methodological coherence, the use of a narrative methodology provided a pathway to reach the stated aim of a deeper understanding of the experience of larger size women accessing healthcare. As the researcher, I embraced a subjectivist epistemology, in that I acknowledge that I cannot
remove myself from being in relationship with the research participants, which I was
cognizant of during analysis and interpretation of the data.

It is my intention for this research to encourage the continued exploration of ways
to support the development of policy and programs that will educate healthcare
professionals and social workers to recognize and address any bias they may have about
larger-bodied people. Additionally, I hope that as a result of this study helping
professionals in healthcare and social work will be inspired to identify and support
women who are struggling with their relationship to healthcare provision to recognize
weight bias for what it is and provide information, space and opportunity for them to
become their own advocates.
References


Appendices

Appendix 1 - Recruitment Poster

Would you like to share your story as a larger sized woman accessing health care?

I am researching the experiences of larger-sized women accessing healthcare in Saskatchewan. I am seeking women volunteers over the age of 18 who consider themselves to be larger-sized (or ‘plus-size’) and have experiences accessing health care.

If you would like to share your story, please feel free to call, text or email researcher Sydney Bell

Call or text: 306-880-5566 / email: bell22sy@uregina.ca

• I am looking for women to volunteer for one or two interviews that may last between 60 and 180 minutes
• This study has received ethics approval from the University of Regina Research Ethics Board and the University of Saskatchewan Behavioral Research Ethics Board

University of Regina
Appendix 2 - Consent Form

Project title: The Stories of Larger-Sized Women Accessing Health Care in Saskatchewan

Date: _______________________

Researcher: Sydney Bell, Graduate Student, Faculty of Social Work, University of Regina, phone: 306-880-5566, bell22sy@uregina.ca

Supervisor: Dr. Darlene Chalmers, Assistant Professor, Faculty of Social Work, email: Darlene.Chalmers@uregina.ca.

Purpose and Objectives of Research:
My name is Sydney Bell. I am a graduate student with the University of Regina in the Faculty of Social Work. I am researching the experiences of larger-sized women accessing healthcare in Saskatchewan. I would like to invite you to participate in a research study called “The Stories of Larger-Size Women Accessing Healthcare in Saskatchewan”. In this study I am hoping to gain an understanding of what it is like for larger-sized women in Saskatchewan to access health care services.

Participation / Procedure
To participate in this study, you will be asked to engage in a maximum of two interviews with the researcher. The interviews will range from 60 to 180 minutes in length. Please feel free to ask any questions regarding the procedures and goals of the study or your role.

Potential Risks:
There are no known or anticipated risks to you by participating in this research.

However, if you need help dealing with issues raised during the interview, you will be given a resource list with contact information for a variety of crisis resources available to you within the community. You may contact these service providers in the event that you could benefit from discussing these issues with a professional counselor. If you choose to be referred by the crisis service to a counseling agency or program in your community, you are responsible for any costs that may be incurred upon accessing these services.

If you should need additional support in regards to strong emotions or feelings that emerge as a result of this interview, a list of support agencies is herein provided that may be of assistance:
Support Services
Agency: Saskatoon Health Region, Adult Community Mental Health
Contact: Centralized Intake / 306-655-4100.
Agency: Family Service Saskatoon
Contact: 306-244-0127 OR http://familyservice.sk.ca/
Agency: Saskatoon Crisis Intervention Service
Contact: 24-HOUR CRISIS LINE PHONE: (306) 933-6200

The researcher, Sydney Bell, has practice experience in social work in the areas of mental health and addictions, community development, and research. These experiences will assist in minimizing the risk of unsupported mental or emotional needs of the participants.

Potential Benefits:
You may also experience benefits from taking part in the project including the opportunity to discuss and explore the challenges and experiences related to the topic. As well, participating in a project that may contribute to improving the experiences of larger-sized women pursuing health may provide a sense of personal satisfaction.

Compensation:
An honourarium of fifty dollars is provided to participants of this study to recompense them for their time and effort for up to a maximum of two interviews.

Confidentiality:
Several steps will be taken to protect your anonymity and identity. While interviews will be digitally-recorded, the digital files will be destroyed once they have been typed up. The typed interviews will NOT contain any mention of your name, and any identifying information from the interview will be removed. The typed interviews will also be kept in a locked filing cabinet at my home, and only myself, my academic supervisor will have access to the interviews.

All information will be destroyed after 5 years time.

Right to Withdraw:
Your participation is voluntary and you can answer only those questions that you are comfortable with. You may withdraw from the research project for any reason, at any time without explanation or penalty of any sort.

Your right to withdraw data from the study will apply until the data has been summarized. After this it is possible that some form of research dissemination will have already occurred and it may not be possible to withdraw your data. If you withdraw, all information from you will be destroyed.

The deadline for withdrawal from this study is December 31, 2015.
All information you share with me will remain confidential. Therefore, I will not be able to share your comments with anyone. Although all talks between you and I are confidential, if you disclose that a child is being abused, or you have feelings of hurting yourself or someone else, I am obliged by law to share that information.

Follow up:
To obtain the results of this study, you can contact me by phone or email. You can reach me by phone at: 306-880-5566 and by email at bell22sy@uregina.ca.

The results from this study will be presented in writing, in journals read by healthcare and other helping professionals, to provide them a better understanding of the experiences of larger-sized women accessing healthcare. The results may also be presented in person to groups to health and helping professionals. At no time, however, will your name or any identifying information revealed.

Questions or Concerns:
If you have any questions, please feel free to contact me at 306-880-5566 bell22sy@uregina.ca, or my thesis supervisor Darlene Chalmers: Darlene.Chalmers@uregina.ca.

This project has been approved on ethical grounds by the UofR Research Ethics Board on (insert date). Any questions regarding your rights as a participant may be addressed to the committee at (585-4775 or research.ethics@uregina.ca). Out of town participants may call collect.

This research project has also been approved on ethical grounds by the UofS Research Ethics Board on (insert date). Any questions regarding your rights as a participant may be addressed to that committee through the Research Ethics Office (Toll Free: 866-966-2975).

SIGNED CONSENT
Your signature below indicates that you have read and understand the description provided; I have had an opportunity to ask questions and my/our questions have been answered. I consent to participate in the research project. A copy of this Consent Form has been given to me for my records.

______________________________     _______________________
Name of Participant                        Signature                       Date

______________________________     _______________________
Researcher’s signature                   Date
Appendix 3 a) University of Saskatchewan Ethics Approval

September 1, 2015

Dr. Darlene Chalmers
Department of Social Work
University of Regina – Saskatoon Campus

RE: The Stories of Larger-Sized Women Accessing Health Care in Saskatchewan

U of R File#: 2015-116; U of S File#: BEH 15-220

Your application for research ethics review has undergone a harmonized review by the University of Saskatchewan and University of Regina. In accordance with the Research Ethics Review Reciprocity Agreement signed by the University of Saskatchewan, University of Regina, and Regina Qu’Appelle Health Region, the University of Saskatchewan REB accepts the Certificate of Approval issued by the University of Regina REB. This letter permits you to conduct research activities as approved by the University of Regina, provided that you maintain a valid and up-to-date Certificate of Approval.

All continuing ethics review will be conducted by the University of Regina REB. The University of Regina is authorized to share all communications pertaining to this file with the University of Saskatchewan REB at their discretion. The University of Saskatchewan REB may provide input into continuing ethical review activities, as agreed upon by both REBs.

The University of Saskatchewan REB reserves the right to revoke the privileges described in this letter at any time in order to conduct their own independent research ethics review of your project. Such a decision would be communicated to you and the University of Regina REB in writing.

Best wishes for your continuing research endeavours.

Sincerely,

Vivian Ramsden, Chair
University of Saskatchewan
Behavioural Research Ethics Board

Cc: University of Regina Research Ethics Board
   Sydney Louise Bell (student)
Appendix 3 b) University of Regina Ethics Approval

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<td>407 – 28th Street West</td>
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<td>Saskatoon, SK S7L 0K7</td>
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<td>Dr. Darlene Chalmers – Social Work</td>
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CERTIFICATION
The University of Regina Research Ethics Board has reviewed the above-named research project. The proposal was found to be acceptable on ethical grounds. The principal investigator has the responsibility for any other administrative or regulatory approvals that may pertain to this research project, and for ensuring that the authorized research is carried out according to the conditions outlined in the original protocol submitted for ethics review. This Certificate of Approval is valid for the above time period provided there is no change in experimental protocol, consent process or documents.

Any significant changes to your proposed method, or your consent and recruitment procedures should be reported to the Chair for Research Ethics Board consideration in advance of its implementation.

ONGOING REVIEW REQUIREMENTS
In order to receive annual renewal, a renewal report must be submitted to the REB Chair for Board consideration within one month of the current expiry date each year the study remains open, and upon study completion. Please refer to the following website for further instructions: [http://www.uregina.ca/research/for-faculty-staff/ethics-compliance/human/forms/ethics-forms.html](http://www.uregina.ca/research/for-faculty-staff/ethics-compliance/human/forms/ethics-forms.html)

[Signature]  
University of Regina  
Research Ethics Board
Appendix 4 - Interview Guide

Research Question: What are the experiences of women who identify as ‘fat’ or ‘overweight’ in accessing healthcare in Saskatchewan?

The qualitative basis and the explorative format of this project suggest the use of a semi-structured interview format, with the intention of providing space for participant’s stories. The researcher will guide the conversation by offering the following topic areas and question prompts for discussion:

- **My Story** – researcher introduction and interest in this topic
- **Main Character** – getting to know the participant, what she wants to share of herself
  - Tell me about yourself – where were you born? Grow up? Go to school? What kind of work do you do? What about your family?
- **Overarching health status story**
  - How would describe your overall health?
  - What ways do you take care of your health?
  - How do you feel about your health?
  - How does your health status impact your life?
  - What things do you do to support your general overall health?
- **Stories of particular health issues**
  - Do you have particular health issues?
  - How do you feel about these health challenges?
  - How do these health challenges affect your life?
  - What actions do you take to address these health challenges?
- **Important characters: health professionals, family, etc.**
  - What relationship do you have with healthcare providers?
  - How do you feel about your relationship with healthcare providers?
  - How does your relationship with your healthcare provider impact your life?
  - What changes or actions have you taken as a result of your interaction with your healthcare provider?
- **Happy stories, sad stories**
  - Tell me about a positive interaction you’ve had at the doctor’s office, or with any other health care provider
  - Do you have any stories of a time when you were sad or unhappy after a doctor visit?
- **Stories that have had a lasting impact.**
  - Are there any health care related stories that have really stuck with you?
  - What stories do you tell to you friend and family most often?
The researcher/interviewer will employ facilitation techniques to create safe space and process that will allow the participants to both identify questions and provide answers within the topic area of the research question.