
Downloaded from: http://insight.cumbria.ac.uk/2242/

Usage of any items from the University of Cumbria Repository ‘Insight’ must conform to the following fair usage guidelines:

Any item and its associated metadata held in the University of Cumbria Institutional Repository (unless stated otherwise on the metadata record) may be copied, displayed or performed, and stored in line with the JISC fair dealing guidelines (available at: http://www.ukoln.ac.uk/services/elib/papers/pa/fair/) for educational and not-for-profit activities provided that

• the authors, title and full bibliographic details of the item are cited clearly when any part of the work is referred to verbally or in the written form a hyperlink/URL to the original Repository record of that item is included in any citations of the work

• the content is not changed in any way

• all files required for usage of the item are kept together with the main item file.

You may not

• sell any part of an item

• refer to any part of an item without citation

• amend any item or contextualise it in a way that will impugn the author/creator/contributor’s reputation

• remove or alter the copyright statement on an item.

The full policy can be found at http://insight.cumbria.ac.uk/legal.html#section5, alternatively contact the University of Cumbria Repository Editor by emailing insight@cumbria.ac.uk.
Background

The Western obesity epidemic affects all socioeconomic groups, ages and genders, but the corpus of empirical research into the practical ways in which patient obesity impacts upon the everyday practice of professional radiographers remains in a fledgling state (Woods, Miller & Sloane, 2016). In the broader healthcare sciences, an array of studies have explored professional-patient communication around a variety of nominally difficult topics, such as mental illness (Nieuwsma & Pepper, 2010), HIV (Silverman, 1997) and, indeed, obesity itself (Swift et al., 2013). In radiological fields, however, has been no research to date into the impacts of a patient’s obesity on clinical communicative dynamics.

Method

A thematic approach informed by Interpretative Phenomenological Analysis (IPA) was used to explore everyday communicative challenges faced by medical imaging professionals when interacting with bariatric patients. Employing a sample of N=8 such professionals, with 5-35 years of front-line experience, open-ended, semi-structured interviews were conducted. Data were analysed in line with the standard idiographic techniques of IPA (Smith, Flowers & Larkin, 2009).

Findings

1. Analysis revealed that stigma and embarrassment around a patient’s obesity was not an innate property of obesity itself, but was embedded in material clinical circumstances (Goffman, 1963), such as examination problems or inappropriate technology.
2. Participants were able to recount cases where a patient had addressed their own obesity with humour or acceptance as freely as they could recount patients who responded with denial or aggression. They were also able to recount three core communicative strategies they had used to avoid embarrassment, or pacify “difficult” situations.
3. However, despite (1) and (2), there prevailed an assumption that obesity was inherently difficult to talk about; this implies an availability heuristic (Gigerenzer, 2004), whereby negative experiences disproportionately inform assumption about “best practice”.
4. Alongside (3), participants made assumptions regarding “appropriate” professional practice that further inhibited their likelihood of talking openly (or at all) to a patient about obesity – i.e. they largely adopted a form of “expressive caution” (Silverman, 1997). Such explicitly “cautious” treatment of a potentially difficult topic has, however, been widely noted to sometimes reinforce stigmas, engendering self-fulfilling prophecies around sensitive matters in medical interaction (Miller, 2013).
5. Finally, it is noted that this assumption of the need for high levels of this expressive caution in obesity communication runs strongly counter the UK NHS “Every Contact Counts” agenda.

Discussion/Conclusion

1. Analysis revealed that stigma and embarrassment around a patient’s obesity was not an innate property of obesity itself, but was embedded in material clinical circumstances (Goffman, 1963), such as examination problems or inappropriate technology.
2. Participants were able to recount cases where a patient had addressed their own obesity with humour or acceptance as freely as they could recount patients who responded with denial or aggression. They were also able to recount three core communicative strategies they had used to avoid embarrassment, or pacify “difficult” situations.
3. However, despite (1) and (2), there prevailed an assumption that obesity was inherently difficult to talk about; this implies an availability heuristic (Gigerenzer, 2004), whereby negative experiences disproportionately inform assumption about “best practice”.
4. Alongside (3), participants made assumptions regarding “appropriate” professional practice that further inhibited their likelihood of talking openly (or at all) to a patient about obesity – i.e. they largely adopted a form of “expressive caution” (Silverman, 1997). Such explicitly “cautious” treatment of a potentially difficult topic has, however, been widely noted to sometimes reinforce stigmas, engendering self-fulfilling prophecies around sensitive matters in medical interaction (Miller, 2013).
5. Finally, it is noted that this assumption of the need for high levels of this expressive caution in obesity communication runs strongly counter the UK NHS “Every Contact Counts” agenda.

References