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Working With Patients Living With Obesity in the Intensive Care Unit

A Study of Nurses' Experiences

Jacqueline Marie Shea, RN, BScN, MScN; Marilou Gagnon, RN, PhD

Increasing numbers of patients living with obesity (PLWO) are admitted to the intensive care unit (ICU). The goal of this qualitative study was to examine the experiences of ICU nurses who work with PLWO using the Othering framework developed by Canales in 2010. The first theme describes how PLWO become “Others” in the ICU. The second theme focuses on exclusionary Othering and how it manifests itself in the way PLWO are cared for and viewed. The third theme sheds light on inclusionary Othering in the form of strategies that are used by nurses to engage with PLWO. The last theme takes a closer look at the ICU environment and how resources impact the experiences of nurses working with PLWO. **Key words:** ICU, intensive care, nurses, nursing, obesity, Othering

THE INTENSIVE CARE UNIT (ICU) is a fast-paced, stressful, demanding and highly technological environment where nurses re-

quire additional education and knowledge to safely provide nursing care to critically ill patients.^{1,2} ICU nurses provide one-on-one care to patients with complex needs (physical, emotional, spiritual, and psychosocial) and medical conditions that require life-sustaining treatments, ongoing diagnostic tests, invasive hemodynamic monitoring and evaluation, assistive devices, pharmacological interventions, parenteral nutrition, fluid and electrolyte management, and prolonged admission with associated risks of complications. Providing nursing care in the ICU is a challenge because of patient acuity, complex care needs, physical demands, ever-changing clinical situations, and competing priorities.² For these same reasons, nurses may encounter additional challenges when caring for patients living with obesity (PLWO) in the ICU context.² Yet, there has been very limited research on the experience of nurses providing care to PLWO and no study conducted in the ICU specifically.

Nurses and other health care providers are not immune to the social construction of obesity and the prevailing views about PLWO. So it is not uncommon for PLWO to

Author Affiliations: *The Ottawa Hospital, Ottawa, Ontario (Ms Shea); and School of Nursing, Faculty of Health Sciences, University of Ottawa, Ottawa, Ontario (Dr Gagnon).*

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Correspondence: Marilou Gagnon, RN, PhD, School of Nursing, Faculty of Health Sciences, University of Ottawa, 451 Smyth Rd, Ottawa, ON K1H8M5, Canada (marilou.gagnon@uottawa.ca).

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encounter negative attitudes and perceptions in health care settings.^{3,4} The literature has demonstrated that there are a number of negative attitudes held by nurses toward PLWO.⁴ Some nurses perceive PLWO as lazy, lacking self-control, noncompliant, and lacking willpower.^{4,5} The nurses' perceptions and attitudes toward these patients reflect those present in Western society. Research has shown that the degree to which nurses hold negative attitudes and perceptions about PLWO can be affected by their professional education, age, personal weight, and previous clinical experiences.^{6,7} In a study conducted by Culbertson and Smolen,⁷ older nurses with more professional education and younger nurses with less clinical experience held more positive attitudes toward PLWO. In addition, nurses who were unhappy with their own body weight and size often viewed PLWO more negatively.⁷

Not all research supports the contention that nurses perceive PLWO negatively. Some studies report that nurses had positive attitudes and perceptions of PLWO.⁴ For example, Zuzelo and Seminara⁸ found that nurses were mindful of and strived to provide respectful patient care for PLWO. The goal of the study undertaken here is not to dismiss findings of positive attitudes and perceptions of PLWO in health care settings, but to acknowledge, as documented by Amy et al,⁹ that this patient population continues to report disrespectful treatment, negative attitudes from others, situations that cause them to feel embarrassment, and unsolicited advice to lose weight from nurses and other health care providers. These experiences can result in higher incidences of health care delay, avoidance of preventative health care, increased illness burden, discomfort during health care interactions, and overall decreased levels of physical, mental, psychological, and emotional health.^{10,11} In a closed and complex environment, such as the ICU, these experiences could have additional effects on health outcomes and the quality of patient care.

Of particular relevance to this study are the findings reported by Culbertson and Smolen.⁷

These authors found that nurses providing care to PLWO often experienced physical discomfort and exhaustion, which contributed to their views of this patient population as more burdensome, challenging, difficult, and so forth. In another study conducted by Drake and colleagues,¹² nurses voiced concerns about their personal safety when providing nursing care to PLWO and feared that these concerns would negatively impact the quality of the care provided. To further complicate the issue, nurses also communicated concerns about the additional workload associated with providing care to this patient population in already strained clinical environments where resources are scarce, equipment and support is not always available, and staffing is insufficient.¹² Building on these findings, the goal of the qualitative study was to look specifically at the experiences of ICU nurses who work with PLWO in a fast-paced, stressful, demanding and highly technological environment, and how these experiences affect the way nurses provide care to this patient population. More specifically, it was designed to describe and explore both inclusionary and exclusionary practices (as defined by Canales) developed by nurses who provide care to PLWO.¹³ Finally, an additional goal of this study was to document the needs of ICU nurses with respect to the care of PLWO.

THEORETICAL FRAMEWORK

The proposed study was guided by Canales's theoretical framework on Othering in nursing practice.¹³ This framework offers a point of entry for studying Othering at the level of nurse-patient interactions and thinking about the ways in which Othering manifests itself in practice. In this framework, the Other is defined as a person (eg, patient, nurse, coworker, and family member) who is viewed as different from one's self.¹³ Canales¹³ describes 2 distinct sets of practices that are used by nurses when they interact with the Other—exclusionary practices and inclusionary practices. Exclusionary practices

use the power in the relationship to differentiate the Other.¹³ In turn, this may contribute to exclusion, neglect, and oppression.¹³ By way of contrast, inclusionary practices use the power in the relationship to build a sense of connectedness, to include, to transform, and to foster stronger social ties with the Other.¹³ In other words, these practices can be used by nurses to engage with the Other in a way that is inclusive and transformative.¹³

It must be noted that, although Othering is composed of dual practices, these practices are not mutually exclusive and they do not stand opposite to each other.¹³ Exclusionary and inclusionary practices are complex; they can manifest in various ways on the basis of personal factors, past experiences, social interactions, context, and so on.¹³ Furthermore, it is important to emphasize that these practices are not fixed. As such, the same person may experience exclusionary Othering in 1 situation and inclusionary Othering in another situation.¹³ Similarly, the same nurse may engage in practices that are exclusionary and inclusionary at the same time and while caring for 1 particular patient or patient population in the ICU.¹³ For example, an ICU nurse might be able to connect with a PLWO through role taking (inclusionary) but fail to connect (exclusionary) with another PLWO who displays particular behaviors or attitudes that make it difficult for that nurse to role take. Labeling such practices as exclusionary or inclusionary is by no means a judgment on the character of that nurse but rather a way of exposing the complexities of nursing care.

METHOD

A qualitative design, which incorporates explorative and interpretive properties, was thought to be an appropriate choice for this research project. Not only are qualitative designs most valuable when researchers seek to examine complex phenomena, but they are also useful in their contribution to knowledge development in research domains where few investigations have been undertaken.¹⁴ For the purpose of this study, we did not

use a traditional qualitative methodology such as phenomenology, grounded theory, or ethnography. Instead, we opted for a “generic” qualitative research design.¹⁵ Over the past decade, there has been a steady increase in the number of qualitative nursing studies that do not use an established qualitative methodology.¹⁵ This has given rise to the term “generic qualitative research” to designate studies that are conducted without a guiding methodological framework.¹⁵

Four basic requirements are necessary to produce a well-done generic qualitative study, including (1) the researcher’s theoretical position, (2) the distinction between method and methodology, (3) the explicit description of rigor criteria, and (4) the identification of the researcher’s analytic lens.¹⁵ In this study, Canales’¹³ framework was used to develop the interview guide, analyze the data, and interpret the findings. It was also used to discuss the implications of the study, including the theoretical implications of the findings. Applied Thematic Analysis (ATA)¹⁶ was used to analyze the data. Tracy’s¹⁷ criteria were used throughout the study to ensure rigor was achieved. Finally, the researcher’s analytic lens and epistemological position were made explicit at the beginning of the study and applied consistently throughout the project.

This study was located within the critical theory paradigm.^{18,19} In critical theory, the researcher and the participants are assumed to be interactively linked, with the values of the researcher inevitably influencing the research process and the production of research findings.^{18,19} As such, research findings are closely linked to the epistemological position of the researcher, the personal and professional experiences of the researcher, the theoretical underpinnings of the research project, and contextual factors. In this paradigm, the research process is seen as a transaction or dialogue between the researcher and the participants.^{18,19} Nursing researchers who work within this paradigm understand the importance of situating nursing practice in context, including the clinical context, institutional context, and social

context. The role of researchers who engage in critical inquiry is to produce more nuanced ways of understanding nursing practice and to work toward transformation by raising awareness, educating, challenging the status quo, or identifying issues that go beyond the individual nurse.

This study was conducted on 2 ICUs at 2 sites of a 1155 bed, multisite, tertiary care health center located in a large urban center in eastern Ontario (Canada). Recruitment of research participants started immediately after the approval by the Research Ethics Boards. Participants were recruited on 2 separate ICUs (ICU #1 and ICU #2) using a research poster, which was displayed in nursing social areas and distributed electronically by the nurse educators. To be included in the study, participants had to be able to communicate in English. Other inclusion criteria included being 18 years and older, currently working as a nurse in ICU #1 or ICU #2, and having at least 1 previous experience of providing care to a PLWO in the ICU. Inclusion of participants was not based on representativeness of ICU nurses. Therefore, all participants who wished to take part in the study were included. There were no specific exclusion criteria for this study.

Over a period of 3 weeks, 11 nurses (see Table 1) were interviewed and they each met with the principal researcher for a period of 30 to 60 minutes. Interview locations were determined on the basis of the preferences and availabilities of participants. If a participant did not wish to be interviewed at the health center or at a preferred location, the interview was conducted in a closed office available to the research team. During the interview process, participants were asked to describe their experiences as ICU nurses working with PLWO, with a particular focus on daily routines, nursing interventions, clinical considerations, and challenges faced in practice. They were also asked to share personal experiences of providing care to PLWO in the ICU context and to reflect on both positive and negative experiences. Participants were encouraged to expand on the

Table 1. Characteristics of Research Participants

Sex	Males	2
	Females	9
Age	25-29	6
	30-34	3
	35-39	1
	40-44	1
Years as RN	<5	3
	5-10	6
	10-14	0
	15-19	1
Years in ICU	>20	1
	<2	1
	2-4	3
	>5	7
Education	Diploma	2
	BScN	7
	MScN	2

Abbreviations: ICU, intensive care unit; RN, registered nurse.

practices or strategies developed to care for PLWO, to describe their needs with respect to this patient population, and to identify areas of improvement in the ICU context.

In this study, data saturation was achieved after 9 interviews. Additional interviews were conducted with 2 participants to confirm that the point of saturation had been reached. Each interview was audio-recorded, transcribed, and reviewed by the researcher promptly after each interview. The methodological approach of ATA¹⁶ was used to analyze the data. In summary, ATA involves the following 4 general steps: (1) read transcriptions, (2) identify possible themes, (3) compare and contrast themes, identifying structure among them, and (4) produce a thematic scheme to describe the research phenomenon.¹⁶ Every transcription was read carefully and the content of the transcription was verified by the principal researcher twice, using the audio file. Data analysis began with the initial coding of the interview identified as the “key interview.” This interview was selected because it offered rich insights, various examples, and balanced descriptions of both positive and negative experiences. The objective of initial coding is to reveal, name,

summarize, and label, line by line, the contents of the transcription.¹⁶ This level of coding was completed for 2 additional interviews. It is important to note that both researchers took part in the coding process to ensure rigor.

As the process continued and commonalities began to emerge, we were able to regroup specific codes into broader codes, and, eventually, to regroup them into themes as they developed. These themes were then used to analyze and color-code subsequent interviews. Throughout this process, the researchers worked carefully to ensure that themes were compared and contrasted, that interrelationships were mapped, and that connections and patterns were identified.¹⁶ All relevant subthemes that emerged during the analysis were labeled and regrouped under a common theme. These subthemes were meant to describe and clearly identify distinct dimensions in the research data.¹⁶ Once the themes and subthemes were fully developed, the transcriptions were reassessed to make sure that they corresponded and reflected the research data.¹⁶ During this process, direct quotes were identified to support each subtheme, and specific quotes were selected to develop the outline for the presentation of the research findings.

RESULTS

During the analysis, 4 themes were identified and divided into subthemes to reflect the experiences of participants. A summary of these findings is presented in Table 2.

Theme 1: working with the Other

The analysis revealed that nurses who work in the ICU construct PLWO as being “different”; that is, nurses consider that PLWO are “different” from other “normal size” patients in the ICU and require “different” nursing care. Participants described working with PLWO as causing “extra physical strain” (nurse 1), “work intensive” (nurse 2), “tiresome” (nurse 3), and as being overall just “harder” (nurse 4) than working with other patients in the ICU. This differentiation occurred in the interviews when PLWO were seen as physically more demanding and requiring more work. It became evident that excess body weight and the demands this placed on ICU nurses played a crucial role in the construction of PLWO as a separate category of patients. All of the nurses interviewed described the experience of working with PLWO by providing concrete examples

Table 2. Summary of Research Findings

Themes	Theme 1 Working With the Other	Theme 2 Exclusionary Othering in the ICU	Theme 3 Inclusionary Othering in the ICU	Theme 4 ICU Environment
Subthemes		Subtheme 2.1 Protecting yourself	Subtheme 3.1 Keeping your distance	Subtheme 4.1 Resources
		Subtheme 2.2 Not being able to provide the care	Subtheme 3.2 Getting to know the patient	Subtheme 4.2 Working with each other
		Subtheme 2.3 Witnessing instances of obesity bias	Subtheme 3.3 Role taking	Subtheme 4.3 Needs

Abbreviation: ICU, intensive care unit.

of the physical strain, challenges, limitations, difficulties, complexities, delays, and complications that come into play when providing ICU nursing care. The subsequent quote illustrates this point:

When there are other people around, especially if you don't have an appropriate lift in the room, right. So, your . . . your logistics take more time to, to set up . . . and then, to do, everything else just takes longer and it takes more physical effort. So checking the lines and tubes, you have to reach further over the patient, which, first off, doesn't make a big difference, but over the course of the 12 hours shift, always leaning over a patient to check for their lines, to listen to their lung sounds, to listen to their heart sounds, to listen to their belly, it's more tiresome than on a regular patient when you can just put your arm out. (Nurse 3: lines 218-224)

The physical difficulties noted by participants included (1) requiring more people to help assess, turn, bathe, transfer, reposition, and mobilize PLWO; (2) having to work with larger-size dressings and ask other team members to help with dressing changes (ie, lifting skin folds); (3) needing additional help (up to 3 persons) to complete simple tasks, such as moving a limb, despite having access to a mechanical lift and other bariatric equipment; and (4) requiring more time to organize nursing care and gather the staff needed to complete physical tasks.

Overall, participants considered that working with PLWO required more time, more work, more physical effort, and more nursing care in general. They found that more nursing care was required because of the medical acuity and the complexity of patients. On numerous occasions, nurses stated that they could not provide care to PLWO the same way they provide care for other patients in the ICU because of the physical effort and resources needed for routine care (ie, hygiene care, turning and positioning, and so on). They also felt somewhat limited when performing nursing skills (ie, auscultating, monitoring, palpating, medicating, and so on) and could not practice the "same way" or with the same amount of time and effort. The following

quote describes how this impacts the quality of the care provided in the ICU context:

I just think, the nursing care is different because more people are needed, I guess, to provide care to one patient, like bathing is a bigger ordeal—for lack of a better word—than it would be for, someone who's not obese. But in terms of how their care is different . . . I don't really know if they receive different care. I just don't know if their care, their personal care, for example, is always as good as a regular size person's care would be, because I feel like people do judge them and people are just not interested in taking the time to provide whatever, you know, extra care they would need to . . . Let's say bathing a patient normally would take you maybe 15 minutes. With an obese patient, if you have to lift up their pannus (*panniculus*) and things like that and it requires more than one person, it's suddenly a 45-minute job. I feel like some nurses aren't willing to provide that extra time to these patients, so they just don't get it. (Nurse 5: lines 139-153)

This quote suggests that physical difficulties experienced by ICU nurses can also overlap with negative attitudes, which, in turn, impact the quality of care. The analysis revealed that nurses experienced feelings of empathy toward PLWO as well as feelings of repulsion, disgust, anger, frustration, blame, and fear. The following quote reveals that nurses may experience negative feelings when providing hygiene care to PLWO:

Usually, when bariatric patients have a belly that's so large, they have a pannus that hangs over, you need three people to wash their pannus and do a good job. And you can stick your hand under and you get the willies because of how it feels and just give a quick wipe. But if you actually want to clean it properly and apply your Canesten cream so their skin doesn't break down, because most of them usually have a yeast infection in the folds of their skin, you need two people to hold up the weight of the pannus while you're cleaning it, right. (Nurse 3: lines 239-249)

This particular quote helps us understand that nurses' feelings originate both from the experience of providing direct physical care to PLWO in the ICU and from the construction of PLWO as "unclean" or "not as clean as the other patients." This is important to take into

account to shed light on the differentiation process that takes place in the ICU context.

Along the same lines, some nurses expressed feelings of frustration, anger and blame while providing care to PLWO in the ICU. This was particularly evident when nurses talked about PLWO not taking an active role in their own health care, lacking the motivation to help themselves during their admission in the ICU, and being “demanding” or “uncooperative.” Some nurses also talked about the challenge of overcoming the pervasive social view that PLWO are responsible for their excess body weight and are to blame for their health condition. There is a differentiation between the PLWO who is to blame for being sick and the patient who is not to be blamed for being sick. This can lead nurses to distance themselves from PLWO and provide less nursing care.

Theme 2: exclusionary practices

Over the course of the analysis, the following subthemes were identified: (1) protecting yourself, (2) not being able to provide care, and (3) witnessing instances of obesity bias.

Subtheme 2.1: protecting yourself

All of the participants mentioned that “protecting yourself” is a priority when providing care to PLWO. When asked to expand on this particular dimension of their work, they provided examples that illustrate how and why PLWO are constructed as potential “threats” or “hazards” in the ICU. The risk of physical injuries was a constant concern among participants to a point where the need to “protect yourself” was identified as a stand-alone subtheme during the analysis. It was not uncommon for nurses to mention that they were fearful of hurting themselves and to stress the importance of physical safety. Feelings of fear were intensified by the risk (anticipated or real) posed by PLWO in an environment that creates limitations (ie, access to equipment, support, and physical help). They were also related to nurses being acutely aware of their own inability to assist PLWO because of phys-

ical limitations and the potential impact on the nurse’s body if “something goes horribly wrong” during their shift.

Physical injuries can occur at any point during the admission in the ICU, which makes nurses feel particularly at risk and reinforces the need to protect oneself. These injuries can occur during basic nursing care such as turning and positioning, as well as during crisis situations. During certain crisis situations, like cardiac arrests, nurses may not be able to protect themselves and may get injured while attending to their professional duties. Furthermore, because of the acuity, complexity, and the urgent nature of the ICU environment, the perception of being at risk for injuries can be amplified. This risk is also amplified by the lack of adequate equipment and supports. These contextual factors need to be taken into consideration in this study because they contribute to nurses feeling the need to protect themselves and to taking the necessary steps to limit their “exposure” to PLWO. Nurses used various strategies to protect themselves from a potential physical injury, including what is known as “clumping” nursing care activities. The following quote shows how this strategy works by reducing the number of times nurses provide physical care to PLWO, decreasing the number of exposures to the risk of being injured, and increasing the likelihood of finding staff members to assist with direct nursing care interventions:

Got to think about your back. Got to make sure that you’re not taking physically, that you’re not taking on too heavy of a task on your own or with not enough help around. Their comfort level in terms of whether or not they’re on the right bed. Whether we need to bring in a bariatric sized bed for them or not. Probably task orienting things as well with them like, you know, if I’ve got, if I know I’ve got to get them washed and then might have dressings as well to do, not like you wouldn’t do that with any other patient anyway, but if it was a more appropriately sized patient or like a thinner patient, you know, if you didn’t manage to get to that one dressing, it’s okay, I can get to it later, but with an obese patient, you probably want to clump all of the physical tasks together all at once so that, you know, you’re not really, having to go over and

repeat yourself so that you're taking care of your own back. (Nurse 1: lines 276-286)

The “clumping” of nursing care interventions that may have otherwise been implemented separately or at different time is a common strategy in the ICU. Although some may argue that this could negatively impact the quality of the care provided to PLWO, participants felt that “clumping” was their way of ensuring that care is actually provided entirely. In other words, “clumping” was described as the best balance nurses could find between providing adequate nursing care, finding other nurses to provide direct assistance, and protecting “their own back.” The “clumping” of nursing care interventions at specific times during a 12-hour shift was also considered essential when attempting to achieve this balance. By grouping *and* timing their interventions, nurses were physically able to provide the care needed by PLWO and do so without compromising their physical safety. These 2 approaches also allowed them to make the best use of the resources available to them on the unit. The findings suggest that nurses are well aware that the care provided to PLWO is not “normal care” and that the way they organize the care is not “what they would normally do.” However, they also suggest that nurses’ ability to provide even the most basic nursing care depends largely on the strategic use of “clumping” to secure the necessary resources and to protect themselves and taking the necessary steps to limit their “exposure” to PLWO.

The interviews revealed that it is not uncommon for ICU nurses to request a change of patient assignment to limit their “exposure” to PLWO. This is often seen as the best option to minimize the risk of being injured because there are no specific measures in place to support nurses who provide care to PLWO in ICU. Some nurses can request a change of assignment because “they don’t want to have to deal with [PLWO] for a full three days” (Nurse 5: line 337). However, participants believe that most nurses tend to request a change of assignment because of physical fatigue, fear

of being injured, physical limitations related to age or physical size, career path (ie, numbers of years left to work), illness or disability insurance, or other responsibilities outside of work. Although the nurses in this study noted that attempts to protect themselves could impact the care of PLWO, they also felt strongly about the fact that these patients should be given the same patient care as any other patient in the ICU.

Subtheme 2.2: not being able to provide care

When nurses talked about their experience with PLWO in the ICU, they often referred to 3 types of situations that made them feel differently (and negatively) about the care they provided—(1) not being able to provide the same care, (2) not being able to provide care, and (3) not being able to provide quality care. Factors such as the patient’s weight, anatomy, illness, condition, and acuity were identified in the interviews. Other factors such as the ICU environment, the available resources, and the priorities of the ICU were also identified as contributing to these 3 types of situations. Providing the same care to PLWO as to any other patients in the ICU was not always possible. This was clearly expressed by participants when they discussed their experience with intravenous medication calculations, dosages, and protocols that are based on a “regular size” patient, central line insertion sites that are limited by the anatomy and the size of PLWO, and standard tests that cannot be done due to the physical size of PLWO (ie, chest x-ray post-central line insertion).

Yes. So I think being turned, having, I guess, you know . . . basically, it would depend on what their problems are. But just being looked after like everyone else is looked after, being medicated properly, having nurses and doctors that know the appropriate amount of medications needed to make those people comfortable, you know. Often times, like, we’re running a Dilaudid and Propofol drip for a 400 pounds person at the same rate that we would for a 100 pounds person. You know, and we’re wondering why this obese person is grimacing,

gagging, kicking, you know, and fighting us to do basic care. Well we're not maybe taking into account that they require more medication than we give our regular sized people. Things like that I guess. (Nurse 5: lines 116-125)

The participants also voiced their inability to conduct the same detailed nursing assessment when working with PLWO. Considering that nursing assessment is of utmost priority for patients admitted to the ICU, this situation was viewed negatively by nurses who often relied on partial clinical information to make decisions about their care. Nurses caring for the PLWO not only face significant limitations when completing their assessments but they also run into "more difficulties" when working with PLWO who require central lines—which is the case for the vast majority of PLWO who are admitted in the ICU. Participants described situations in which they were not able to provide the care needed because of the medical acuity and complexity of PLWO who are hemodynamically unstable. The following quote provides insight into the ICU context as well as the complicated decision making that nurses face when they have to complete even the most basic nursing care. It also emphasizes that providing or not providing hygiene care, for example, is a complex decision when working with PLWO, because, unlike "other patients," they can decompensate quickly when they are turned in the bed.

... So yes one night, one night we had a, a, a very obese patient. And he had a [tracheostomy] ... had been with us quite some time having respiratory difficulties. Having trouble breathing and had soiled the bed. Like soiled most of the bed and was beyond being able to just leave him in it. And he had arrested, he had a respiratory arrest and then a cardiac arrest because it was just ... I don't think it would have necessarily happened had he not, had we been able to change him in another way. Like sometimes we can at least lift a leg and clean one side and lift another leg and clean the other side and get a large portion of it cleaned that way and then quickly flip one way, flip the other way, get a whisk on it at least. It's better. But you can't do that with obese patients. You just can't. There's too much of them in the bed, like ... And that's what happened like he just arrested because

we couldn't ... find another way around having to change it out ... And I don't think anybody foresaw that he would ever arrest. For sure. We thought, "Okay, well, you know, we'll probably have to put him back at 100%, you know, make sure the RT is close by." You know, "We'll do this as quick as possible." Nobody could ever foresaw it. We suspected he would desaturate. Maybe require some good suctioning, bagging or something like that ... and there was big ... there was some discussion on how to ... best attempt this. But he arrested. (Nurse 2: lines 541-584)

In the same way that nurses faced situations where they could not provide hygiene care or reposition a patient, they were also faced with situations where they were unable to do life-saving interventions such as cardiopulmonary resuscitation. Participants were often confronted with situations where they were not able to provide quality care to PLWO. When compared with the care they "normally" provide to other ICU patients, participants considered that PLWO did not get turned as much and did not get the same kind of skin care. Patients living with obesity did not receive the same quality of care when undergoing diagnostic tests like x-rays and ultrasounds. In addition, quality of care was negatively impacted because diagnostic tests (ie, computed tomographic scan) could not be done even though they were medically indicated.

The analysis revealed that nurses face numerous questions and a great deal of unknowns when they provide care to PLWO in the ICU. This is largely due to the fact that the environment, the care, the tests, and the treatments are designed for "non-obese patients." During 1 of the interviews, 1 participant went on to highlight how this impacts the quality of the care and how nurses feel about the care they provide to PLWO—"I think I just feel like I'm on the edge of having provided that patient with safe care" (Nurse 7: line 174). These feelings are important to acknowledge because nurses are regularly confronted with situations where they are not able to provide PLWO with "the care that they should be getting" (Nurse 9: line 109).

Subtheme 2.3: witnessing instances of obesity bias

In this section, the focus is on “instances of obesity bias,” or, in other words, instances when participants were challenged by their own past (negative) experiences with PLWO as well as instances when their patient was the target of derogatory comments and jokes, negative attitudes and behaviors, and inappropriate conversations. During the interviews, it became evident that nurses were not only challenged physically when they provided care to PLWO but they were also challenged by their own past experiences as well as their experiences with colleagues who displayed negative and discriminatory attitudes toward PLWO—the same colleagues who nurses rely on to help with nursing care interventions and direct physical care when they work with PLWO. Participants acknowledged that past negative experiences can have an impact on the way nurses approach PLWO and attend to their care. It is almost as if these experiences are “carried over” to other PLWO, days, weeks, and months later. The phenomenon of “carrying past negatives experiences over” to other patients seemed to be more common with “obese people” versus “regular sized people.” In light of the findings presented above, this phenomenon seems to indicate that obesity bias takes many different forms in the ICU context and that it can also be intensified when nurses are challenged both physically, mentally, personally, and emotionally in certain care situations. In addition, many nurses mentioned how they were better able to remember the negative experiences of providing care to PLWO more vividly than the positive experiences. This is consistent with observations made during the interviews. When asked to comment about their experience of providing care to PLWO, participants would automatically refer to negative experiences.

Witnessing these instances of obesity bias was considered to be a significant challenge when providing care to PLWO. For instance, 1 participant acknowledged that “dealing with the negative comments from your co-worker

next to you is challenging through a 12-hour shift” (Nurse 10: lines 175-176). Examples of obesity bias from colleagues included derogatory jokes and comments, negative attitudes and behaviors, and inappropriate conversations. Instances of obesity bias frequently took place outside the work space and during break periods. When these types of situations were mentioned in the interviews, they were often described as “inappropriate” but serving some kind of purpose. That is, they allowed nurses to “vent,” to acknowledge the actual physical size and weight of the patient, and to get validation for the work they were doing, often with very limited or no support.

Absolutely, I think, you know, they just want justification that maybe, “Yes, you’re doing a good job, you know, caring for this 650 pound patient today or doing the best that you can. I saw how huge he was. I get why you’re having a stressful day.” You know, I feel these nurses come into the break room totally dishevelled, flabbergasted, frustrated. And they’re either just seeking validation from their peers that it’s okay that they feel frustrated, that they feel tired, that, you know, they don’t feel like they’re being supported in the way that they need to be. (Nurse 5: lines 278-284)

These situations were difficult for nurses because “shutting down” a colleague who is behaving inappropriately and unprofessionally is not easy. As this next participant points out, nurses who face these difficult situations will try to control what is taking place in their room (ie, the room of their patient), but they may not feel confident enough to pursue this outside the room. Nurses may also find it difficult to “shut down” colleagues due to fears of repercussions, including colleagues refusing to help or being less willing to help with physical care.

The influence of bedside communication, in the form of a bedside shift report between nurses, arose during the data analysis. Here, it is important to point out that shift report is done *at the bedside* in the ICU and not at the nursing station, as happens in other units in the hospital. At the start of a shift, nurses have to deal with their own past experiences with PLWO and preconceptions about what their

shift will look like, experiences and preconceptions that, in and of themselves, present a challenge. Nurses are further challenged by bedside communication during shift report. The analysis revealed that shift report can “frame” the nurse-patient relationship in a negative way, whether the patient is a PLWO or not. In fact, the bedside shift report can result in nurses “passing on” exclusionary views of the patient to the following nurse. The following quote demonstrates this point:

I'm even guilty of that. Whether it's an obese patient or not, you know, if you get a report from a nurse that's had a bad day with a patient for whatever reason, if they start their report by saying to you, “You're going to have a horrible night or day because X, Y and Z happened on my shift,” it's hard for me, you know, to then look at my patient with a clean slate and think, “Well, you know what? It's a new 12 hours. My day might not have to be so bad.” But when that's given to you right away and you're sitting down, ready to take over the care of this patient, you're automatically set up with a negative, you know, image or, you know, with a negative framework to work from. So it's difficult to get away from that. (Nurse 5: lines 369-377)

It is important to keep in mind that exclusionary views of PLWO can be “picked up” during shift report, meaning that these views may or may not be present prior to the report. In this sense, obesity bias during shift report can perpetuate negative views of the PLWO from 1 shift to another. Participants also explained that a “negative report” at change of shift is often linked to nurses leaving their shift “feeling a bit frustrated” or “exasperated” after providing care to PLWO for 12 hours. As 1 participant stated, this “makes it difficult to start your shift on a positive note” (Nurse 3: line 27). Nevertheless, the analysis revealed that nurses use different inclusionary strategies to make sure the “negative report” does not take over their shift. These strategies are described in the next section.

Theme 3: inclusionary othering

The following inclusionary practices were identified during the analysis: (1) keeping

your distance, (2) getting to know your patient, and (3) role taking.

Subtheme 3.1: keeping your distance

During the interviews, participants described their efforts to “keep their distance” from the negative comments that were made during the shift report to remain “impartial” and “professional.” Nurses also described keeping their distance from instances of obesity bias that take place throughout the 12-hour shift. Nurses attempted to keep their distance by approaching PLWO with a “clean slate” and by getting to know their patients. In addition to approaching the patient with a “clean slate,” participants tried not to listen to other nurses or, as 1 participant explained, tried to let the information that was not relevant to the care of the patient just “wash away.”

I listen to report, but I really, I'm . . . I, I don't internalize everything that is said to me in report, I guess that's what I want to say. I pick out what I feel is relevant and just let the rest wash away. So I don't go in, I mean even though you say I don't go in with a preconceived, you know, expectation of my patient, they make sure I've heard it and I've heard a lot of, “They don't want to do anything” or “This patient is combative” or what. But I actually love proving people wrong. So I try and go in pretty neutrally, but, certainly, reports can influence people and how their approach is with a patient, absolutely. (Nurse 7: lines 887-900)

This particular quote suggests that some nurses make a conscious and active effort to let the information “wash away” and to not internalize the information, so they can remain impartial when assigned to a PLWO. Interestingly, participants described how, by keeping their distance, they were able to reframe the nurse-patient relationship in a positive way and used end-of-shift report to “pass this on” to the next nurse. From this distancing perspective, end-of-shift report was seen as an opportunity to actively oppose the obesity bias and provide a buffer from the views of the oncoming nurse.

Attempts to positively reframe the nurse-patient relationship were often combined

with other inclusionary practices, such as keeping a distance from personal views on obesity (ie, obesity as an outcome of someone eating too much). Participants also tried to keep a distance from “societal judgments” related to obesity, which implied that they had to “put aside” their own attitudes, ideas, opinions, values, and so forth. This was considered to be challenging for nurses who provided care to PLWO in the ICU:

Challenging . . . challenging physically, and challenging mentally in terms of, how I perceive my client in an overall sense . . . you know, trying to put aside, I'd say the biggest part is trying to put aside societal judgments or the stigmas that society puts on the obese population and trying to, yes, put that to rest so that I can go in and take care of my patient as who they are as an individual and not with the stigmas attached to them. I'd say, yes, and the physical part is probably the biggest challenge that I have, but . . . And, actually, oh yes, that's probably it. It's just it's a bit of a challenge in terms of physically and mentally, how I, how I perceive them and how I have to work around their, their condition in order to take care of them. (Nurse 1: lines 5-13)

The analysis revealed that “leaving these judgements at the door before going into the patient's room” is challenging for nurses who work in the ICU because they are not immune to negative societal perceptions of obesity. Participants acknowledged that keeping one's distance had its own limitations because “nurses are people.” In other words, nurses internalize the same negative societal perceptions as other people in society do. Yet, they felt it was important for them to keep a distance as much as possible from these perceptions to maintain a professional stance and “look after PLWO the way you are supposed to.”

Subtheme 3.2: getting to know the patient

In addition to keeping their distance, participants made a conscious effort of “getting to know their patients” on a personal level. This inclusionary practice required nurses to approach PLWO with a “clean slate” and es-

tablish a connection with the patient as a person. Getting to know the patient was essentially described as a way for ICU nurses to look past physical appearance and to connect with the patient on a personal or human level.

But I try with every patient just to look them in the eyes and see them for who they are and, and try to make some kind of connection and just not see all the extra adipose tissue and just see who's in the bed or not see the ventilator or the central line, and just kind of deal with people on a human level. (Nurse 10: lines 176-179)

During the analysis, it became apparent that it was easier for nurses to get to know their patients if some form of communication could be established. For example, if intubated patients were able to communicate through writing or if patients were not intubated and were able to communicate verbally. The ability to connect with the patient through different forms of communication is not always possible in the ICU context. Since the majority of PLWO are intubated and sedated in the ICU, nurses may not be able to get to know their patients. This is important to consider because it may limit the use of this inclusionary practice by ICU nurses and, in some way, contribute to the depersonalization and dehumanization of PLWO. In situations where nurses were unable to get to know the patient because that patient was unable to respond, speak, interact, or communicate in writing, they considered that getting to know the patient through the family was another way to see past their own attitudes, ideas, opinions, values, and so forth.

The easiest case for me to get over that is if I have a patient that, is cognitively aware and able to communicate with me . . . because the minute I get to talk to a patient and, for some reason for me, the minute they have a voice, they become an individual and all of those stigmas kind of do float away and you get to know the patient for who they are and who they are as a person, their personalities, their own quirks and characteristics as opposed to kind of what you're seeing from the doorway, which is obviously just an obese patient as soon as you kind of look at them. Once you go

in and kind of get to talk to them and get a feel for who they are, the whole, for me, the whole thing changes. If it's somebody that isn't able to respond to me, I'll try my best, once a family member comes in to visit to maybe learn a little bit more about them and who they were, who they are at home so that it takes, it takes who they are for as my patient, into a more personal level and not quite so vague where I feel like the . . . the societal stereotypes can attach more easily. (Nurse 1: lines 20-35)

The ability to connect with the patient through the family may be encumbered if family members (1) are not present, (2) do not want to provide insight into the personal life of the patient, or (3) do not view the patient in a positive way. Establishing a connection with the family can also help nurses understand the life story of the patient and his or her personal struggles outside of the ICU context. Getting to know the patient on a personal level included getting to know the story of that person. Getting to know that story was challenging at times for ICU nurses. Participants recognized that the idea of establishing some sort of personal connection had its own limitations because the patient may exhibit an undesirable characteristic (ie, being depressed or unpleasant) or may fit a certain stereotype (ie, lacking motivation). When this is the case, it can be harder for nurses to connect with the patient as a person. During the analysis, it was noted that ICU nurses tend to connect more easily with PLWO who comply with medical advice, acknowledge that they have a problem and make an effort to correct it. Nurses would view these patients as persons with whom it is easier to relate and who are easier to get to know on a personal level. Inclusionary practices may be seen more favorably and may be more easily implemented when PLWO adopt the recommended approach to viewing and addressing their health situation—being positive, happy, goal oriented, and compliant. Unsurprisingly, then, these practices may not be used as frequently, or may not have the same impact, when PLWO are seen as negative, difficult, noncompliant, depressed, and lazy.

Subtheme 3.3: role taking

Role taking was another inclusionary practice described by participants to foster a human connection with PLWO and to acknowledge their point of view. Participants often reflected on how they would feel if they were in the same position as their patients and commented on this role taking process during the interviews. Role taking was used as a gateway to understanding and providing compassionate nursing care that is patient centered. The ability to role take was influenced by a number of factors including, but not limited to, how well the nurse could relate to the PLWO and their condition and how much personal understanding was available to the nurse regarding the challenges faced by PLWO. A number of participants explained how they were able to draw from their own personal experiences with family members who are obese to facilitate role taking.

[One of my family members] is quite overweight. And he's obese. And so I feel like, I guess this is where things get tricky, I don't want to, I don't, I feel like as a nurse, I don't want to blow the line between sympathy and compassion. Because I feel like sympathy can sometimes turn into a negative approach to things . . . and so I did feel a bit sympathetic for him, because of my [family member]. But I also feel like it gave me, like, I don't know, kind of gave me an up, in speaking with the family because I do have personal experience with it. So I kind of drew upon those [experiences]. (Nurse 8: lines 199-218)

The previous quote illustrates how role taking, as an inclusionary practice, creates a personal connection between the nurse and the patient. However, role taking is also challenging and may not be practical for nurses who struggle to see the situation through the eyes of their patient, nurses who hold strong negative views toward obesity, nurses who cannot begin to understand how the patient has arrived at this point in their life, or nurses who have no personal understanding of what this experience might look like. Some participants mentioned that it was difficult for them to role take, or, as 1 participant stated, "to kind of put myself in their shoes and how like if I was

that size, how I'd want to be treated" (Nurse 11: lines 451-451). The challenging process of role taking or "trying to put yourself in someone else's shoes" was also acknowledged by another participant.

Yes, so, emotional support sometimes is difficult... because it's, it's hard to empathize sometimes... Because it's hard to get into somebody's... an obese patient's shoes. I'm very small and I have no idea what they go through... and I can, I can listen to the problems, but it's hard sometimes to try and, and direct a conversation with them, because, like I said, I can't put myself in their shoes sometimes. I don't, I don't know what they go through. I don't know what they, what they're living every day... sometimes it's hard too because you know it's a physiological problem and they can't, they can't do anything about it... It's a little bit hard when it's lifestyle and I know I wouldn't chose that kind of lifestyle. So it's hard for me some times to understand why somebody would choose a lifestyle that would lead them to being so obese... Sometimes, it's just... yes, it's hard to, for me, to understand what the rationale is behind their, their lifestyle... so it's hard to, to give support sometimes that way, but I always try and listen if I can listen. (Nurse 4: lines 134-155)

As suggested by this participant, it was particularly difficult for nurses to role take when they viewed obesity as a result of bad choices, unhealthy behaviors, lack of motivation, and sedentary lifestyle. Nurses also emphasized how hard it was for them to "understand what PLWO are going through" because they have a hard time relating to their situation.

Theme 4: ICU environment

The analysis revealed that these resources vary from 1 unit to another and can be divided into 3 categories—physical resources, informational resources, and human resources. These resources can positively or negatively impact the experiences of nurses working with PLWO and the way nurses work with each other in the ICU context.

Subtheme 4.1: resources

The majority of participants had similar responses to what *physical resources* are avail-

able to them in the ICU environment. Nurses stated that the rooms in the ICU are bigger to allow them to have more persons and equipment in the room to help. There are ceiling lifts in most patient rooms, and there are portable lifts present on the unit if a ceiling lift is not present in the patient's room. There are special beds, called bariatric beds, which have special mattresses to diminish skin breakdown. Nurses spoke of these resources as essential to the care of the PLWO as well as their ability to decrease the number of persons needed to turn and reposition, bathe, and mobilize the patient. A number of nurses identified that ICU physical resources and even basic necessities, such as patient gowns, are not always easily accessible or available. This lack of accessibility or availability can affect the experiences of nurses caring for PLWO as well as the patient's experience of being hospitalized in the ICU. In addition, it can negatively impact the quality of nursing care and can create situations in which nurses are unable to uphold their professional standards. The following quote supports this idea:

And also, not having enough gowns, like I... like that young guy, we, wanted to get him washed up. He wanted to move on, he wanted to do things and get out of bed and get... And there wasn't even a... We had called for bariatric gowns. And they said they would send them up. In two days, we never had ones that were big enough to fit him. So he would wear, he was wearing a sheet. (Nurse 11: lines 209-214)

A number of participants went on to say that even when bariatric gowns are ordered, they are usually not sent to the unit that day or even the next day. This particular example indicates that nurses may face unnecessary organizational barriers when trying to access the most basic resources for PLWO. Nurses not only encountered difficulties associated with limited accessibility and availability of physical resources but also lacked awareness of what physical resources are available, and where to find them on the unit or in the hospital. The lack of accessibility, availability, and awareness of physical resources was associated with an increased workload

and increased risk or actual occurrences of physical injuries among ICU nurses. The analysis revealed that the experience of providing care to PLWO may be negatively or positively shaped by accessibility, availability, and awareness of existing physical resources in the ICU. It also sheds light on the limits of existing physical resources and how these impact the experiences of nurses in the ICU. For instance, 1 participant noted, “We’ve got the bariatric lifts which you can’t really use for a dressing” (Nurse 2: line 31). The following quote describes further what it is like to provide nursing care with the equipment present in the ICU:

... my... patient, the commode actually sat, the limit was lower than what his weight was. And so I asked our team leader if I should try it, because I didn’t want him to have a disaster. She said, “Yes, try it.” But I was kind of like, “Hail, Mary” like put him on the commode and hope it doesn’t like break underneath him. (Nurse 11: lines 189-192)

Nurses talked about the limits of physical resources and challenges associated with the use of the bariatric equipment in the ICU. This quote describes the physical difficulties nurses experience despite the availability and accessibility of bariatric lifts.

... yes, you have those, you can use a mechanical lift for turns to a certain degree. But there’s no mechanical lift to help you lift an arm or a leg, or even lifting their shoulders and their heads to switch the pillow underneath. People’s shoulders weigh a lot, but on a bariatric patient it weighs a lot more. And there’s really no good body mechanics for lifting the shoulders of somebody. (Nurse 3: lines 255-260)

Bariatric equipment was described as a key component of the experience of caring for PLWO in the ICU. On numerous occasions, participants voiced the importance of bariatric equipment (specifically ceiling lifts, bariatric beds, and slider sheets) when providing care to PLWO. Working with lifts and bariatric beds was described by participants as a way to safely care for the PLWO while protecting themselves from physical injury, decreasing their physical workload, and organiz-

ing their care. As previously noted, if bariatric equipment is not accessible to nurses, more persons are required to help them, and the nurses and PLWO may encounter nursing care delays.

Participants identified a number of *informational resources* that impacted their experiences of providing care to PLWO. These resources were deemed essential to ensure patient safety and to provide competent care in the ICU context. These resources included dietitians, social workers, spiritual care workers, and pharmacists. Many participants described the role of ICU pharmacists and how they assist nurses in determining safe and effective medications dosages because existing protocols for intravenous medications are not adapted to PLWO and may create situations in which nurses have to administer dosages that fall outside existing ICU protocols. Nurses who work night shifts face significant barriers accessing these resources because dietitians, social workers, spiritual care workers, and pharmacists only work 8-hour shifts during the day and are not available between the hours of 7:00 PM to 7:00 AM. When asked about their experiences of providing care to PLWO, participants also insisted on the importance of *human resources*, namely, physiotherapists, occupational therapists, orderlies, and nurse colleagues. Nurses described how they work with each other throughout a 12-hour shift, whether it is to cover during breaks, to help with turns, bathing, linen changes, skin assessments, and procedures such as x-rays, dressing changes, or bone marrow biopsies, for example.

Subtheme 4.2: working with each other

This study highlights the impact of resources (especially physical and human resources) on the way nurses work with each other in the ICU context. During the interviews, participants clearly explained that the relationship between nurses providing care to PLWO and their nurse colleagues is influenced by what is available and what is not available within the ICU environment. There

was a general consensus that “it’s difficult to find volunteers to come and help you, you know, when you need to provide basic care to those patients” (Nurse 5: lines 15-16). A number of the interviews revealed that, although the care of PLWO is not that different from that of other ICU patients, it requires more persons to assist with the most basic physical tasks, higher levels of teamwork throughout the 12-hour shift, and more coordination to get other nurse colleagues to help. For example, nurses described situations when, instead of requiring 2 persons for a turn, nurses required 4 to 5 persons to complete this task every 2 hours and also to provide physical care. Because of the increased numbers of nurses needed to complete basic tasks for PLWO, these nurses must work together more often and for greater amounts of time. Consequently, this phenomenon impacts the way nurses work with each other. In turn, it creates situations where it is difficult to find other nurses to help and situations where nurses have to rely heavily on colleagues to assist them.

... I think it works pretty much the same way with bariatric patients as it does with a non-bariatric patient. You just need more of it instead of having one or two people to help you, you need four to eight depending on the patient’s weight. ... Trying to find that many people is difficult because everybody’s busy. At least most people are busy. And people who are not busy and don’t like to help usually make themselves scarce ... (Nurse 3: lines 388-394)

Two types of experiences were described by participants. The first experience was based on the feeling or perception that some of their nurse colleagues found ways to be busy with their own patient to avoid situations where they would be asked to provide extra help to complete physical tasks. The second experience was described by a few participants who noted that assistance from nurse colleagues depended on which staff members were scheduled for a given shift. Although nurses acknowledged that their nurse colleagues may not be able to assist them because they are legitimately preoccupied with their

own patients, or are unavailable because of the needs of more critically ill patients on the unit, they also talked about avoidance, reluctance, and unwillingness to help as common reactions faced by nurses who provided care to PLWO. A few participants noted that some colleagues did not seem to “care as much” about PLWO and expressed negative feelings toward this patient population, which, in turn, impacted their willingness to assist with physical care and provide help when needed. A number of participants also observed that there was a tendency to ask nurses whom they knew would help them, thus creating situations where the same nurses were being repeatedly asked and used to assist in patient care. This resulted in physical fatigue or injury and inadvertently led to nurses refusing to provide assistance and avoiding situations where help was needed. The following quote affirms the above idea:

I think, if you’re on for two or three days and your buddies are on for two or three days, I think you end up, drawing on the, the greater unit more. Like any available nurse to your room kind of thing. Because I think everybody, everybody gets fatigued. (Nurse 2: lines 306-309)

A nurse’s willingness to help their colleagues with the physical care of the PLWO is complicated and perhaps affected by 1 factor or a combination of the factors that have been discussed thus far. The analysis revealed that a nurse’s previous experiences with physical injuries (often when providing care to a PLWO) could decrease the likelihood of a nurse assisting a colleague or being available to help. It was understood that nurses with past injuries were often concerned with the risk of physical injury when helping with PLWO, and, ultimately, they could be actively protecting themselves by not helping others on the unit. A few of the ICU nurses interviewed denied ever having difficulties or problems getting assistance and help from nurse colleagues. Many nurses strived to provide PLWO with good nursing care and to work as a cohesive team. Nurses often worked with each other in an attempt to maintain the same level of care

for PLWO, to fill the existing gaps in physical resources, and to compensate for the limitations of bariatric equipment at hand. As such, it was noted on multiple occasions that providing care to PLWO in the ICU required additional support from nursing colleagues.

Subtheme 4.3: needs

In light of the findings presented above, there were a wide variety of needs identified over the course of the interviews. These needs will be presented and discussed in a subsequent publication.

DISCUSSION

The study findings capture the idea that PLWO are not only physically “different” from other patients, but they also require “different” nursing care. Although nurses spoke of trying to provide PLWO with the same care as any other patient in the ICU, they often were unable to do so (because of obstacles related to lack of resources to assist with physical care, ICU nursing care, and routine care such as turning and positioning), or they were unsure how to provide this care (due to lack of clinical guidelines, practice standards, resources, and so forth). In addition, nurses experienced feelings of wanting to provide PLWO with the same level of care and, on the other contrary, opposing feelings of repulsion, disgust, anger, frustration, blame, and fear, which were often produced and intensified by the work environment. These conflicting feelings often occurred simultaneously while nurses provided care for PLWO, and this phenomenon allowed for exclusionary Othering to manifest itself in different ways. During the analysis, it became clear that where nurses work and how they feel about their work were 2 important drivers of exclusionary Othering in the ICU—even more so than how nurses feel about PLWO and obesity more generally.

This study suggests that the ICU context functions as a driver of exclusionary Othering. Building on the work of Johnson and

colleagues²⁰ who conducted a study of South Asian immigrant women in Vancouver, it is important to recognize that exclusionary Othering *is* contextual. Their ethnographic study revealed that organizational culture, work environment, and institutional practices contribute to Othering by excluding patients who do not easily fit into routines, the standardized clinical pathways, and the “normal” ways of providing care that are seen as essential components of a streamlined and efficient health care system. In this context, health care providers, including nurses, often construct patients who are “different” or require “different” care as “*difficult to deal with* and *as burdens* on an already resource strapped system” (emphasis added).^{20(p266)} Johnson and colleagues also found that “emphasizing how health care institutions provide uniform and efficient services, have rigid appointment times and treatment schedules and limited time spent with patients compounded exclusionary experiences [within their research setting].”^{20(p266)} This study had very similar contextual factors as well as similar findings to those noted by Johnson et al,²⁰ including rigid treatment schedules and routine practices that need to be carried out in a specific way, where nurses reported opposing feelings of working with PLWO, and where PLWO were viewed as being “*difficult to deal with*.” Nurses’ feelings and views arose from the extra effort associated with caring for PLWO and operating within an environment developed for those who are “normal weight,” as well as the contextual factors noted above. In this sense, the ICU should be seen and understood as a space that makes Othering possible simply by being what it is—a space that is characterized by fixed routines or by unalterable schedules designed for a certain kind of patient, and that is organized in a way that is meant to be efficient.

In this study, nurses encountered many difficulties ranging from accessing equipment and basic supplies (eg, gowns), finding additional support and resources to assist with care, accessing clinical information and guidelines, making sound clinical decisions that are

evidence-informed, attending to all the care needs of the patient, stabilizing and monitoring the patient, intervening in an effective way in life-threatening situations, and providing safe nursing care. These difficulties were linked to feelings of inadequacy for not being able to provide optimal care to PLWO. They were also linked to nurses finding themselves in situations where they felt on “the edge of providing safe care.” The study findings suggest that the way nurses feel about the care they provide to PLWO is an additional driver of exclusionary Othering. Although this is not reflected in the work of Johnson and colleagues²⁰ or in the original framework of Canales,¹³ it is consistent with the work of Jacob²¹ in the field of forensic psychiatry. In fact, Jacob found that the way nurses feel about the care they provide and the potential for recovery in long-term forensic psychiatric settings shapes the way they feel about their patients.²¹ In Jacob’s study, nurses were much more likely to disconnect and disengage from patients when they perceived their care as meaningless or as having little impact on recovery.²¹ This phenomenon signals that exclusionary Othering is not only driven by the context of *where nurses work*, but it also driven by the way nurses *feel about their work*. Here, we see many similarities between the findings of this study where nurses’ feeling on the edge of providing safe care to PLWO in the ICU during times of critical illness and Jacob’s findings of nurses feeling on the verge of providing meaningless care to forensic psychiatric patients over the course of years and sometimes decades.²¹ In both cases, nurses are questioning the care provided to the groups within their specific settings due to nurses’ experiences with Othering, both inclusionary and exclusionary. The patient population and the care setting are different, but the exclusionary process at play is very much the same—and the Othering framework would benefit from further development to provide more insight into the relationship between Othering, the patient population, and patient care settings.

IMPLICATIONS OF THE RESEARCH FINDINGS

Implications for nursing practice

Nurses working in the ICU would benefit from the development of strategies to prevent them from becoming emotionally, mentally, and physically fatigued as a result of providing care to PLWO. Whether this is achieved through a lift team being made available to assist with physical care (including bathing, turning, positioning, and dressing changes) or the development of patient care guidelines to assist nurses who provide care to PLWO in complex and acute situations, every possible solution to support ICU nurses should be carefully considered at the organizational level. These solutions should include changes in policies and procedures, including unit procedures. As suggested by this study, failing to see the need for and develop innovative solutions to support ICU nurses who provide care to PLWO could have a detrimental impact on the quality of care provided, the clinical outcomes, the experience of patients, and on the nurses themselves. These solutions may also reduce exclusionary Othering processes at play in the ICU and may support the implementation of inclusionary practices that are consistent with nursing values, professional obligations, ethical responsibilities, and standards of practice.

Debriefing is 1 innovative strategy that could be implemented to provide ICU nurses with the opportunity to talk about a negative experience, verbalize their concerns, express their needs, and find support. Debriefing could also assist nurses in overcoming their negative experiences; these experiences were revealed to have long-lasting effects and seemed to be the easiest to recall when participants were asked about their experience of providing care to PLWO. In fact, positive experiences seemed to have little or no impact on ICU nurses and did not significantly impact the way nurses talked about what it means to provide care to PLWO. Understanding that 1 negative experience with a PLWO can alter the way nurses approach, feel about,

perceive, and care for other PLWO in the ICU affirms the importance of finding solutions that can alter this “chain reaction.”

Finally, ensuring that sufficient equipment is available and accessible should be a priority in the ICU context. A list of equipment available to all staff, along with the necessary details (eg, description of the equipment, purpose, instructions, and location), should be easy to find on the unit. This may be seen as a minor change, but it would save time, reduce the sense of frustration that many participants described in this study, improve patient care, decrease the risk of injuries, and improve the experience of providing care to PLWO more generally.

Implications for research

In light of the study findings, further research should focus on the experience of PLWO in the ICU. It should also include the perspective of family members who are often very present in the ICU and act as the point of contact between the patient and nurse—especially when the patient is intubated, sedated, or unable to respond to social interaction. The experiences of other team members in the ICU (eg, pharmacists, dieticians, staff physicians, residents, medical students, social workers, physiotherapists, managers, team leaders, and spiritual care providers) would also be extremely valuable because the ICU is based on an interprofessional model of care. All of these professionals would be in a position to provide information that can deepen our understanding of the overall “care experience” in the ICU. Finally, comparative studies between hospitals and ICU units could help explore the impact of space, education, support, and resources on the experience of providing care to PLWO. It would also allow researchers to examine how organizational factors play a role in shaping that experience.

Implications for nursing theory

As suggested by this study, Othering is a fluid process. In other words, ICU nurses can feel and act in an exclusionary manner and

then feel and act in an inclusionary manner. When this process is separated into 2 distinct dimensions (exclusionary or inclusionary), there is a risk of constructing nurses as “good” or “bad,” rather than focusing on the complexity of exclusionary Othering and the limits of inclusionary Othering. There is also a risk of decontextualizing Othering to a point where the focus is placed solely on the nurse—how that nurse acts, thinks, and provides care to PLWO. In this study, the social context, the ICU environment, the organization of nursing care, and the nature of the care provided in the ICU were major drivers of exclusionary Othering. Limitations of inclusionary Othering were also highlighted, and theoretical assumptions were questioned (eg, patient is awake and talking, nurse is able to relate, and time is available to connect). In addition, Othering appears to be a group process as much as it is an individual process. Thinking about fluidity, context, and group dynamics could provide new directions for the framework developed by Canales.¹³ Furthermore, it could help researchers who study Othering in nursing to examine new ways of understanding exclusionary and inclusionary practices. The study findings also suggest that there is a need for further development of the framework to look more critically at organizational influences that contribute to or limit these practices (eg, structural Othering).

Implications for education

At the undergraduate level, the framework developed by Canales¹³ could inform the content of specific nursing courses (eg, professionalism and ethics courses) to ensure that nursing students learn to recognize the process of Othering and the drivers of Othering in clinical practice, in addition to specific inclusionary strategies that can be used when working with patients who are seen as Others. This framework would meet an educational need and also provide nursing students with the tools to think about and assess how power can be used in ways that are exclusionary or inclusionary. Nursing

students would also benefit from the inclusion of bariatric sensitivity training and nursing content that is tailored to the care needs of PLWO. At an organizational level, continuing education for registered nurses who work in the ICU should include bariatric sensitivity training as well as in-service presentations that meet the clinical, practical, and informational needs of nurses. Although a workshop informed by the framework of Canales¹³ could also be beneficial to ICU nurses, it would need to be accompanied by important changes to the care environment (resource availability and allocation, support, equipment, workload management, etc) to have a “real” impact on the care provided to PLWO. As suggested by this study, education is not the only answer, but it is part of the solution.

FINAL REMARKS

The study findings revealed that the experience of nurses who provide care to PLWO

in the ICU environment is much more complicated than nurses simply having negative attitudes, perceptions, and feelings toward this patient population. Therefore, if nurse researchers focus predominantly on these negative attitudes, perceptions, feelings, and individual behaviors, they only observe a small aspect of the larger picture and, by extension, a small portion of the problem. As this study has shown, there are social, situational, organizational, and institutional influences that have not been acknowledged to date in the literature despite the fact that they contribute to exclusionary Othering; these unacknowledged factors influence nurses themselves and the way they provide care to PLWO as a result. Exploring these influences in a subsequent study could provide insight into how this phenomenon takes place in the ICU and might raise important questions on the role of macro-level influences in shaping nurse-patient interactions.

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